

Evidence of Coverage

Your Medicare and MassHealth Standard (Medicaid) Health Benefits and Services and Prescription Drug Coverage as a Member of

- **Tufts Health Plan Senior Care Options (HMO SNP)**



This booklet gives you the details about your Medicare and MassHealth Standard (Medicaid) health care and prescription drug coverage from January 1 – December 31, 2015. It explains how to get coverage for the health care services and prescription drugs you need. **This is an important legal document. Please keep it in a safe place.**

This plan, Tufts Health Plan Senior Care Options, is offered by Tufts Health Plan (When this Evidence of Coverage says “we,” “us,” or “our,” it means Tufts Health Plan. When it says “plan” or “our plan,” it means Tufts Health Plan Senior Care Options.)

Tufts Health Plan is an HMO plan with a Medicare contract and a contract with the Commonwealth of Massachusetts Medicaid program. Enrollment in Tufts Health Plan depends on contract renewal. Tufts Health Plan Senior Care Options is a voluntary MassHealth (Medicaid) program in association with the Executive Office of Health and Human Services (EOHHS) and Centers for Medicare & Medicaid Services (CMS).

This information is available for free in other languages. Please contact our Customer Relations number at 1-855-670-5934 for additional information. (TTY users should call 1-855-670-5936). Hours are Monday – Friday, 8:00 a.m. – 8:00 p.m. (From Oct. 1 – Feb. 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. Customer Relations also has free language interpreter services available for non-English speakers.

Esta información está disponible gratis en otros idiomas. Por favor, comuníquese con nuestro departamento de Servicios para Miembros al 1-855-670-5934 para obtener información adicional. (Los usuarios de TTY deben llamar al 1-855-670-5936). El horario es de lunes a viernes de 8:00 a.m. a 8:00 p.m. (del 1 de octubre al 14 de febrero los representantes están disponibles los 7 días de la semana, de 8:00 a.m. a 8:00 p.m. Nuestro departamento de Servicios para Miembros tiene servicios de intérprete de idiomas disponibles gratis para las personas que no hablan inglés

This information is available in a different format, including large print.

Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2016.

2015 Evidence of Coverage

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SECTION 1 Introduction

Section 1.1	You are enrolled in Tufts Health Plan Senior Care Options, which is a specialized Medicare Advantage Plan (Special Needs Plan)
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You are covered by both Medicare and MassHealth Standard (Medicaid):

- **Medicare** is the Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (kidney failure).
- **MassHealth (Medicaid)** is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. MassHealth (Medicaid) coverage varies depending on the state and the type of MassHealth (Medicaid) you have. Some people with MassHealth Standard (Medicaid) get help paying for their Medicare premiums and other costs. Other people also get coverage for additional services and drugs that are not covered by Medicare.

You have chosen to get your Medicare and MassHealth Standard (Medicaid) health care and your prescription drug coverage through our plan, Tufts Health Plan Senior Care Options.

There are different types of Medicare health plans. Tufts Health Plan Senior Care Options is a specialized Medicare Advantage Plan (a Medicare “Special Needs Plan”), which means its benefits are designed for people with special health care needs. Tufts Health Plan Senior Care Options is designed specifically for people who have Medicare and who are also entitled to assistance from MassHealth Standard (Medicaid).

Because you get assistance from MassHealth Standard (Medicaid), you will pay less for some of your Medicare health care services. MassHealth Standard (Medicaid) also provides other benefits to you by covering health care services such as prescription drugs, long-term care and/or home- and community-based services that are not usually covered under Medicare. You will also receive “Extra Help” from Medicare to pay for the costs of your Medicare prescription drugs. Tufts Health Plan Senior Care Options will help manage all of these benefits for you, so that you get the health care services and payment assistance that you are entitled to.

Tufts Health Plan Senior Care Options is run by a non-profit organization. Like all Medicare Advantage Plans, this Medicare Special Needs Plan is approved by Medicare. The plan also has a contract with the Massachusetts Medicaid program to coordinate your MassHealth Standard (Medicaid) benefits. We are pleased to be providing your Medicare and MassHealth Standard (Medicaid) health care coverage, including your prescription drug coverage, long-term care and/or home- and community-based services.

Section 1.2 What is the *Evidence of Coverage* booklet about?

This *Evidence of Coverage* booklet tells you how to get your Medicare and MassHealth Standard (Medicaid) medical care, long-term care and/or home- and community-based services, and prescription drugs covered through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

This plan, Tufts Health Plan Senior Care Options, is offered by Tufts Health Plan. (When this *Evidence of Coverage* says “we,” “us,” or “our,” it means Tufts Health Plan. When it says “plan” or “our plan,” it means Tufts Health Plan Senior Care Options.)

The word “coverage” and “covered services” refers to the medical care, long-term care and/or home-and community-based services, and services and the prescription drugs available to you as a member of Tufts Health Plan Senior Care Options.

Section 1.3 What does this Chapter tell you?

Look through Chapter 1 of this *Evidence of Coverage* to learn:

- What makes you eligible to be a plan member?
- What is your plan’s service area?
- What materials will you get from us?
- What is your plan premium and how can you pay it?
- How do you keep the information in your membership record up to date?

Section 1.4 What if you are new to Tufts Health Plan Senior Care Options?

If you are a new member, then it’s important for you to learn what the plan’s rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* booklet.

If you are confused or concerned or just have a question, please contact our plan’s Customer Relations (phone numbers are printed on the back cover of this booklet).

Section 1.5 Legal information about the *Evidence of Coverage*

It’s part of our contract with you

This *Evidence of Coverage* is part of our contract with you about how Tufts Health Plan Senior Care Options covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs (Formulary)*, and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called “riders” or “amendments.”

The contract is in effect for months in which you are enrolled in Tufts Health Plan Senior Care Options between January 1, 2015 and December 31, 2015.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of Tufts Health Plan Senior Care Options after December 31, 2015. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2015.

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services) and the Commonwealth of Massachusetts must approve Tufts Health Plan Senior Care Options each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

SECTION 2 What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements
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You are eligible for membership in our plan as long as:

- You live in our geographic service area (section 2.3 below describes our service area)
- -- *and* -- you have both Medicare Part A and Medicare Part B
- -- *and* -- you do not have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different plan that was terminated.
- *and* -- you meet the special eligibility requirements described below.

Special eligibility requirements for our plan

Our plan is designed to meet the needs of people who receive certain MassHealth Standard (Medicaid) benefits. (MassHealth (Medicaid) is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources.) To be eligible for our plan you must be:

- Aged 65 or older
- Enrolled in MassHealth Standard (Medicaid)
- Residing in our geographic service area (section 2.4 describes our service area)
- Not diagnosed with End Stage Renal Disease (ESRD)
- Living at home or in a long-term-care facility (The member cannot be an inpatient at a chronic or rehabilitation hospital or reside in an intermediate care facility for the mentally retarded.)

You may also qualify if you are eligible for the Frail Elder Waiver (FEW). For information about the FEW program, contact Aging Services Access Points (ASAPs) at 1-800-AGE-INFO (1-800-243-4636) TTY: 1-800-872-0166.

Section 2.2 What are Medicare Part A and Medicare Part B?

When you first signed up for Medicare, you received information about what services are covered under Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally helps cover services provided by hospitals (for inpatient services, skilled nursing facilities, or home health agencies).
- Medicare Part B is for most other medical services (such as physician’s services and other outpatient services) and certain items (such as durable medical equipment and supplies).

Section 2.3 What is MassHealth Standard (Medicaid)?

MassHealth (Medicaid) is a joint Federal and state government program that helps with medical and long-term care costs for certain people who have limited incomes and resources. Each state decides what counts as income and resources, who is eligible, what services are covered, and the cost for services. States also can decide how to run their program as long as they follow the Federal guidelines.

In addition, there are programs offered through MassHealth (Medicaid) that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These “Medicare Savings Programs” help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full MassHealth (Medicaid) benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

Section 2.4 Here is the plan service area for Tufts Health Plan Senior Care Options

Although Medicare is a Federal program, Tufts Health Plan Senior Care Options is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes these counties in Massachusetts: Barnstable, Bristol, Essex, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester.

If you plan to move out of the service area, please contact Customer Relations (phone numbers are printed on the back cover of this booklet). When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.


It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

SECTION 3 What other materials will you get from us?

Section 3.1 Your plan membership card – Use it to get all covered care and prescription drugs

While you are a member of our plan, you must use your membership card for our plan whenever you get any services covered by this plan and for prescription drugs you get at network pharmacies. Here's a sample membership card to show you what yours will look like:

SAMPLE FRONT

TUFTS  Health Plan		HMO SNP
Senior Care Options		
Medical, Prescription Drug and Dental Plan		Copays
PCP	FIRSTNAME LASTNAME, MD	\$0 PCP OV
		\$0 Spec OV
		\$0 ER
RxBin	004336	MedicareR Prescription Drug Coverage
RxPCN	MEDDADV	
RxGRP	RX8657	
ID	S12345678	Issued: MM/DD/YYYY
Name	FIRSTNAME LASTNAME	CMS - H2256 - 029

SAMPLE BACK

Submit Medical Claims to: Tufts Health Plan Senior Care Options P.O. Box 9183 Watertown, MA 02471-9183	Submit Pharmacy Claims to: CVS/Caremark Medicare Part D Paper Claims P.O. Box 52092 Phoenix, AZ 85072-2092
Submit Dental Claims to: DentaQuest Tufts Health Plan SCO 12121 N. Corporate Parkway Mequon, WI 53092 1-888-309-6508	Important Numbers: Provider Relations: 1-800-279-9022 Customer Relations: 1-855-670-5934 TTY: 1-855-670-5936
For Benefit information, pre-authorization or other assistance, call Tufts Health Plan Senior Care Options Customer Relations Department M-F, 8:00am-8:00pm. Health Care Professional available 24 hrs a day 7 days a week. Tufts Health Plan Senior Care Options (HMO SNP) Website www.thmp.org/sco	

As long as you are a member of our plan **you must not use your red, white, and blue Medicare card** to get covered medical services (with the exception of routine clinical research studies and hospice services). Keep your red, white, and blue Medicare card in a safe place in case you need it later.

Here's why this is so important: If you get covered services using your red, white, and blue Medicare card instead of using your Tufts Health Plan Senior Care Options membership card while you are a plan member, you may have to pay the full cost yourself.

If your plan membership card is damaged, lost, or stolen, call Customer Relations right away and we will send you a new card. (Phone numbers for Customer Relations are printed on the back cover of this booklet.)

Section 3.2	The <i>Provider Directory</i>: Your guide to all providers in the plan's network
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The *Provider Directory* lists our network providers. *Every year that you are a member of our plan, we will send you either a new Provider Directory or an update to your Provider Directory.*

What are “network providers”?

Network providers are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost-sharing as payment in full. We have arranged for these providers to deliver covered services to members in our plan.

Why do you need to know which providers are part of our network?

It is important to know which providers are part of our network because, with limited exceptions, while you are a member of our plan you must use network providers to get your medical care and services. The only exceptions are emergencies, urgently needed care when the network is not available (generally, when you are out of the area), out-of-area dialysis services, and cases in which Tufts Health Plan Senior Care Options authorizes use of out-of-network providers. See Chapter 3 (*Using the plan's coverage for your medical services*) for more specific information about emergency, out-of-network, and out-of-area coverage.

If you don't have your copy of the *Provider Directory*, you can request a copy from Customer Relations (phone numbers are printed on the back cover of this booklet). You may ask Customer Relations for more information about our network providers, including their qualifications. You can also see the *Provider Directory* at <http://www.thpmp.org/sco>, or download it from this website. Both Customer Relations and the website can give you the most up-to-date information about changes in our network providers.

Section 3.3 *The Provider Directory: Your guide to pharmacies in our network*

What are “network pharmacies”?

Our *Provider Directory* gives you a complete list of our network pharmacies – that means all of the pharmacies that have agreed to fill covered prescriptions for our plan members.

Why do you need to know about network pharmacies?

You can use the *Provider Directory* to find the network pharmacy you want to use. This is important because, with few exceptions, you must get your prescriptions filled at one of our network pharmacies if you want our plan to cover (help you pay for) them.

If you don't have the *Provider Directory*, you can get a copy from Customer Relations (phone numbers are printed on the back cover of this booklet). At any time, you can call Customer Relations to get up-to-date information about changes in the pharmacy network. You can also find this information on our website at <http://thpmp.org/sco>.

Section 3.4 *The plan's List of Covered Drugs (Formulary)*

The plan has a *List of Covered Drugs (Formulary)*. We call it the “Drug List” for short. It tells which Part D prescription drugs are covered by Tufts Health Plan Senior Care Options. The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the Tufts Health Plan Senior Care Options Drug List.

In addition to the drugs covered by Part D, some prescription drugs are covered for you under your MassHealth Standard (Medicaid) benefits. The Drug List tells you how to find out which drugs are covered under MassHealth Standard (Medicaid).

The Drug List also tells you if there are any rules that restrict coverage for your drugs.

We will send you a copy of the Drug List. The Drug List we send to you includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the printed Drug List. If one of your drugs is not listed in the Drug List, you should visit our website or contact Customer Relations to find out if we cover it. To get the most complete and current information about which drugs are covered, you can visit the plan's website (<http://www.thpmp.org/sco>) or call Customer Relations (phone numbers are printed on the back cover of this booklet).

Section 3.5	The <i>Part D Explanation of Benefits</i> (the “Part D EOB”): Reports with a summary of payments made for your Part D prescription drugs
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When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the *Part D Explanation of Benefits* (or the “Part D EOB”).

The *Part D Explanation of Benefits* tells you the total amount you, or others on your behalf, have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. Chapter 5 Section 11 (*What you pay for your Part D prescription drugs*) gives more information about the *Explanation of Benefits* and how it can help you keep track of your drug coverage.

A *Part D Explanation of Benefits* summary is also available upon request. To get a copy, please contact Customer Relations (phone numbers are printed on the back cover of this booklet).

SECTION 4 Your monthly premium for Tufts Health Plan Senior Care Options

Section 4.1	How much is your plan premium?
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You do not pay a separate monthly plan premium for Tufts Health Plan Senior Care Options. You must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by MassHealth (Medicaid) or another third party).

Some members are required to pay other Medicare premiums

Some members are required to pay other Medicare premiums. As explained in Section 2 above, in order to be eligible for our plan, you must maintain your eligibility for MassHealth Standard (Medicaid) as well as be entitled to Medicare Part A and enrolled in Medicare Part B. For most Tufts Health Plan Senior Care Options members, MassHealth (Medicaid) pays for your Part A premium (if you don’t qualify for it automatically) and for your Part B premium. If MassHealth (Medicaid) is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain a member of the plan.

Some people pay an extra amount for Part D because of their yearly income; this is known as Income Related Monthly Adjustment Amounts, also known as IRMAA. If your income is \$85,000 or above for an individual (or married individuals filing separately) or \$170,000 or above for married couples, **you must pay an extra amount directly to the government (not the Medicare plan)** for your Medicare Part D coverage.

- If you have to pay an extra amount, Social Security, **not your Medicare plan**, will send you a letter telling you what that extra amount will be. If you had a life-changing

event that caused your income to go down, you can ask Social Security to reconsider their decision.

- **If you are required to pay the extra amount and you do not pay it, you will be disenrolled from the plan.**
- For more information about Part D premiums based on income, visit <http://www.medicare.gov> on the Web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Your copy of *Medicare & You 2015* gives information about these premiums in the section called “2015 Medicare Costs.” Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2015* from the Medicare website (<http://www.medicare.gov>). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.3 Can we change your monthly plan premium during the year?

No. We are not allowed to begin charging a monthly plan premium during the year. If the monthly plan premium changes for next year we will tell you in September and the change will take effect on January 1.

SECTION 5 Please keep your plan membership record up to date

Section 5.1 How to help make sure that we have accurate information about you

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage including your Primary Care Physician.

The doctors, hospitals, pharmacists, and other providers in the plan’s network need to have correct information about you. **These network providers use your membership record to know what services and drugs are covered and the cost-sharing amounts for you.** Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse’s employer, workers’ compensation, or MassHealth Standard (Medicaid))
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If you receive care in an out-of-area or out-of-network hospital or emergency room

- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study

If any of this information changes, please let us know by calling Customer Relations (phone numbers are printed on the back cover of this booklet).

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

Read over the information we send you about any other insurance coverage you have

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see Section 7 in this chapter.)

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Customer Relations (phone numbers are printed on the back cover of this booklet).

SECTION 6 We protect the privacy of your personal health information

Section 6.1 We make sure that your health information is protected

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

For more information about how we protect your personal health information, please go to Chapter 7, Section 1.4 of this booklet.

SECTION 7 How other insurance works with our plan

Section 7.1 Which plan pays first when you have other insurance?

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that pays second, called the "secondary payer," only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-stage Renal Disease (ESRD):
 - If you're under 65 and disabled and you or your family member is still working, your plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
 - If you're over 65 and you or your spouse is still working, the plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

MassHealth Standard (Medicaid) and TRICARE never pay first for Medicare-covered services. They only pay after Medicare and/or employer group health plans have paid.

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Customer Relations (phone numbers are printed on the back cover of this booklet). You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

Chapter 2. Important phone numbers and resources

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SECTION 1 Tufts Health Plan Senior Care Options contacts (how to contact us, including how to reach Customer Relations at the plan)

How to contact our plan's Customer Relations

For assistance with claims, billing or member card questions, please call or write to Tufts Health Plan Senior Care Options Customer Relations. We will be happy to help you.

Method	Customer Relations – Contact Information
CALL	<p>1-855-670-5934</p> <p>Calls to this number are free. Representatives are available Monday - Friday, 8:00 a.m. - 8:00 p.m. (From Oct. 1 - Feb. 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.</p> <p>Health Care Professional available 24 hours a day, 7 days a week.</p> <p>Customer Relations also has free language interpreter services available for non-English speakers.</p>
TTY	<p>1-855-670-5936</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free. Representatives are available Monday - Friday, 8:00 a.m. - 8:00 p.m. (From Oct. 1 - Feb. 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.</p>
FAX	<p>617-972-9487</p>
WRITE	<p>Tufts Health Plan Senior Care Options Attn: Customer Relations P.O. Box 9181 Watertown, MA 02471-9181</p>
WEBSITE	<p>http://www.thpmp.org/sco</p>

How to contact us when you are asking for a coverage decision about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For more information on asking for coverage decisions about your medical care, see Chapter 8 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

You may call us if you have questions about our coverage decision process.

Method	Coverage Decisions for Medical Care – Contact Information
CALL	1-855-670-5934 Calls to this number are free. Calls to this number are free. Representatives are available Monday - Friday, 8:00 a.m. - 8:00 p.m. (From Oct. 1 - Feb. 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.
TTY	1-855-670-5936 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Calls to this number are free. Representatives are available Monday - Friday, 8:00 a.m. - 8:00 p.m. (From Oct. 1 - Feb. 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.
FAX	617-972-9487
WRITE	Tufts Health Plan Senior Care Options Attn: Customer Relations P.O. Box 9181 Watertown, MA 02471-9181

How to contact us when you are making an appeal about your medical care

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your medical care, see Chapter 8 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Appeals for Medical Care – Contact Information
CALL	1-855-670-5934 Calls to this number are free. Representatives are available Monday - Friday, 8:00 a.m. - 8:00 p.m. (From Oct. 1 - Feb. 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.
TTY	1-855-670-5936 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Representatives are available Monday - Friday, 8:00 a.m. - 8:00 p.m. (From Oct. 1 - Feb. 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.
FAX	617-972-9516
WRITE	Tufts Health Plan Senior Care Options Attn: Appeals and Grievances P.O. Box 9193 Watertown, MA 02471-9193

How to contact us when you are making a complaint about your medical care

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your medical care, see Chapter 8 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Complaints about Medical Care – Contact Information
CALL	1-855-670-5934 Calls to this number are free. Representatives are available Monday - Friday, 8:00 a.m. - 8:00 p.m. (From Oct. 1 - Feb. 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.
TTY	1-855-670-5936 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Calls to this number are free. Representatives are available Monday - Friday, 8:00 a.m. - 8:00 p.m. (From Oct. 1 - Feb. 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.
FAX	617-972-9516
WRITE	Tufts Health Plan Senior Care Options Attn: Appeals and Grievances P.O. Box 9193 Watertown, MA 02471-9193
MEDICARE WEBSITE	You can submit a complaint about Tufts Health Plan Senior Care Options directly to Medicare. To submit an online complaint to Medicare go to www.medicare.gov/MedicareComplaintForm/home.aspx .

How to contact us when you are asking for a coverage decision about your Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs. For more information on asking for coverage decisions about your Part D prescription drugs, see Chapter 8 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Coverage Decisions for Part D Prescription Drugs – Contact Information
CALL	1-855-670-5934 Calls to this number are free. Representatives are available Monday - Friday, 8:00 a.m. - 8:00 p.m. (From Oct. 1 - Feb. 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.
TTY	1-855-670-5936 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Representatives are available Monday - Friday, 8:00 a.m. - 8:00 p.m. (From Oct. 1 - Feb. 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.
FAX	617-673-0956
WRITE	Tufts Health Plan Senior Care Options Attn: Customer Relations P.O. Box 9181 Watertown, MA 02471-9181
WEBSITE	http://www.thpmp.org/sco

How to contact us when you are making an appeal about your Part D prescription drugs

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your Part D prescription drugs, see Chapter 8 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Appeals for Part D Prescription Drugs – Contact Information
CALL	1-855-670-5934 Calls to this number are free. Calls to this number are free. Representatives are available Monday - Friday, 8:00 a.m. - 8:00 p.m. (From Oct. 1 - Feb. 14 representatives are available 7 days a week, 8:00 a.m. - 8:00 p.m.) For urgent Part D Appeals on weekends and holidays, call Customer Relations and follow the prompts. Your call will be returned by the on-call Appeals & Grievances Specialist within 24 hours.
TTY	1-855-670-5936 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Representatives are available Monday - Friday, 8:00 a.m. - 8:00 p.m. (From Oct. 1 - Feb. 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.
FAX	617-972-9516
WRITE	Tufts Health Plan Senior Care Options Attn: Appeals and Grievances P.O. Box 9193 Watertown, MA 02471-9193

How to contact us when you are making a complaint about your Part D prescription drugs

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your Part D prescription drugs, see Chapter 8 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Complaints about Part D prescription drugs – Contact Information
CALL	1-855-670-5934 Calls to this number are free. Representatives are available Monday - Friday, 8:00 a.m. - 8:00 p.m. (From Oct. 1 - Feb. 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.
TTY	1-855-670-5936 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Representatives are available Monday - Friday, 8:00 a.m. - 8:00 p.m. (From Oct. 1 - Feb. 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.
FAX	617-972-9516
WRITE	Tufts Health Plan Senior Care Options Attn: Appeals and Grievances P.O. Box 9193 Watertown, MA 02471-9193
MEDICARE WEBSITE	www.medicare.gov
	You can submit a complaint about Tufts Health Plan Senior Care Options directly to Medicare. To submit an online complaint to Medicare go to www.medicare.gov/MedicareComplaintForm/home.aspx .

Where to send a request asking us to pay for our share of the cost for medical care or a drug you have received

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 6 (*Asking us to pay a bill you have received for covered medical services or drugs*).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 8 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) for more information.

Method	Payment Request – Contact Information
CALL	1-855-670-5934 Representatives are available Monday - Friday, 8:00 a.m. - 8:00 p.m. (From Oct. 1 - Feb. 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. Calls to this number are free.
TTY	1-855-670-5936 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Representatives are available Monday - Friday, 8:00 a.m. - 8:00 p.m. (From Oct. 1 - Feb. 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.
FAX	617-972-9487
WRITE	Tufts Health Plan Senior Care Options P.O. Box 9183 Watertown, MA 02471-9183
WEBSITE	http://www.thpmp.org/sco

SECTION 2 Medicare (how to get help and information directly from the Federal Medicare program)

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called “CMS”). This agency contracts with Medicare Advantage organizations including us.

Method	Medicare – Contact Information
CALL	<p>1-800-MEDICARE, or 1-800-633-4227</p> <p>Calls to this number are free.</p> <p>24 hours a day, 7 days a week.</p>
TTY	<p>1-877-486-2048</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free.</p>
WEBSITE	<p>http://www.medicare.gov</p> <p>This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state.</p> <p>The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:</p> <ul style="list-style-type: none"> • Medicare Eligibility Tool: Provides Medicare eligibility status information. • Medicare Plan Finder: Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an <i>estimate</i> of what your out-of-pocket costs might be in different Medicare plans.
WEBSITE (continued)	<p>You can also use the website to tell Medicare about any complaints you have about Tufts Health Plan Senior Care Options:</p> <ul style="list-style-type: none"> • Tell Medicare about your complaint: You can submit a complaint about Tufts Health Plan Senior Care Options directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. <p>If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)</p>

SECTION 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Massachusetts, the SHIP is called SHINE (Serving Health Information Needs of Elders).

SHINE is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

SHINE counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. SHINE counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

Method	SHINE (Serving Health Information Needs of Elders) (Massachusetts SHIP) – Contact Information
CALL	1-800-243-4636 (1-800-AGE-INFO)
TTY	1-800-872-0166 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Call the number above for the address of the SHINE program in your area.
WEBSITE	www.mass.gov

SECTION 4 Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare)

There is a Quality Improvement Organization for each state. For Massachusetts, the Quality Improvement Organization is called Livanta.

Livanta has a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of

care for people with Medicare. Livanta is an independent organization. It is not connected with our plan.

You should contact Livanta in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

Method	Livanta Massachusetts's Quality Improvement Organization) – Contact Information
CALL	1-866-815-5440
TTY	1-866-868-2289 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Livanta BFCC-QIO Program 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for reconsideration.

If you move or change your mailing address, it is important that you contact Social Security to let them know.

Method	Social Security – Contact Information
CALL	1-800-772-1213 Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday. You can use Social Security’s automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday.
WEBSITE	http://www.ssa.gov

SECTION 6 MassHealth (Medicaid) (a joint Federal and state program that helps with medical costs for some people with limited income and resources)

MassHealth (Medicaid) is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for MassHealth Standard (Medicaid). Tufts Health Plan Senior Care Options members must be enrolled in MassHealth Standard (Medicaid).

MassHealth Standard (Medicaid) pays for services not covered by Medicare, and will cover certain services once the Medicare benefit is exhausted. See Chapter 4 in this booklet for more information about benefits covered by MassHealth Standard (Medicaid).

In addition, there are programs offered through MassHealth (Medicaid) that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These “Medicare Savings Programs” help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full MassHealth (Medicaid) benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full MassHealth (Medicaid) benefits (SLMB+).)
- **Qualified Individual (QI):** Helps pay Part B premiums.

- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

If you have questions about the assistance you get from MassHealth (Medicaid), contact MassHealth (Medicaid).

Method	MassHealth (Massachusetts’s Medicaid program) – Contact Information
CALL	1-800-841-2900
TTY	1-800-497-4648 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	MassHealth Customer Service Center 55 Summer Street Boston, MA 02110
WEBSITE	www.mass.gov

The Massachusetts Community Care Ombudsman Program helps people enrolled in MassHealth Standard (Medicaid) with service or billing problems. They can help you file a grievance or appeal with our plan.

Method	Massachusetts Community Care Ombudsman Program – Contact Information
CALL	1-617-727-7750 or 1-800-AGE-INFO (1-800-243-4636)
TTY	1-800-872-0166 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Executive Office of Elder Affairs One Ashburton Place, 5 th Floor Boston, MA 02108
WEBSITE	www.mass.gov

The Massachusetts Long-Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

Method	Massachusetts Long-Term Care Ombudsman Program – Contact Information
CALL	1-617-727-7750 or 1-800-AGE-INFO
TTY	1-800-872-0166 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Executive Office of Elder Affairs One Ashburton Place, 5 th Floor Boston, MA 02108
WEBSITE	www.mass.gov

SECTION 7 Information about programs to help people pay for their prescription drugs

Medicare’s “Extra Help” Program

Because you are eligible for MassHealth Standard (Medicaid), you qualify for and are getting “Extra Help” from Medicare to pay for your prescription drug plan costs. You do not need to do anything further to get this “Extra Help.”

If you have questions about “Extra Help,” call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048 (applications), 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 7 am to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778; or
- Your State MassHealth (Medicaid) Office (applications) (See Section 6 of this chapter for contact information).

If you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has established a process that allows you to either request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us.

- Please contact our Customer Relations Department if you need assistance with obtaining or proving best available evidence. The phone number is on the back cover of this booklet.

- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Customer Relations if you have questions (phone numbers are printed on the back cover of this booklet).

Medicare Coverage Gap Discount Program

Because you get “Extra Help” from Medicare to pay for your prescription drug plan costs, the Medicare Coverage Gap Discount Program does not apply to you. You already have coverage for your prescription drugs during the coverage gap through the “Extra Help” program.

For people who don't get “Extra Help,” the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs to Part D enrollees who have reached the coverage gap. These enrollees also receive some coverage for generic drugs. If you have any questions about the Medicare Coverage Gap Discount Program, please contact Customer Relations (phone numbers are printed on the back cover of this booklet).

SECTION 8 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address.

Method	Railroad Retirement Board – Contact Information
CALL	1-877-772-5772 Calls to this number are free. Available 9:00 am to 3:30 pm, Monday through Friday If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are <i>not</i> free.
WEBSITE	http://www.rrb.gov

SECTION 9 You can get assistance from Senior Agencies

In Massachusetts, the following agencies offer help to seniors age 60 or older and their families, friends, and caregivers:

- **Aging Services Access Points**
Aging Services Access Points (ASAPs) are one-stop entry points for all of the services and benefits available to seniors in Massachusetts. These agencies provide information, applications, direct services, and referrals.
- **Councils on Aging / Senior Centers**
Councils on Aging (COAs) are local volunteer organizations that offer information and direct services to seniors, their caregivers, and other people with aging issues. COAs are part of the local government, and work with other senior agencies and city/town departments to provide social, recreational, health, safety, and educational programs for seniors in their communities.
- **800AgeInfo**
800-AGE-INFO is a Web site as well as a phone number where seniors and their families can get information about programs and services for the elderly in Massachusetts. It is a joint project of the Massachusetts Executive Office of Elder Affairs and the Mass Home Care Association.

For information on any of these agencies call the Massachusetts Executive Office of Elder Affairs AgeInfo line at 1-800-AGE-INFO (1-800-243-4636) (TTY 1-800-872-0166) or visit their Web site at <http://www.massresources.org/senior-agencies>.

Chapter 3. Using the plan’s coverage for your medical and other covered services

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SECTION 1 Things to know about getting your medical care and other services covered as a member of our plan

This chapter explains what you need to know about using the plan to get your medical care and other services covered. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, and other medical care that are covered by the plan.

For the details on what medical care and other services are covered by our plan, use the benefits chart in the next chapter, Chapter 4 (*Benefits Chart, what is covered*).

Section 1.1 What are “network providers” and “covered services”?

Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our plan:

- **“Providers”** are doctors and other health care professionals licensed by the state to provide medical services and care. The term “providers” also includes hospitals and other health care facilities.
- **“Network providers”** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network generally bill us directly for care they give you. When you see a network provider, you usually pay nothing for covered services.
- **“Covered services”** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4.

Section 1.2 Basic rules for getting your medical care and other services covered by the plan

As a Medicare and MassHealth Standard (Medicaid) health plan, Tufts Health Plan Senior Care Options must cover all services covered by Original Medicare and other services.

Tufts Health Plan Senior Care Options will generally cover your medical care as long as:

- **The care you receive is included in the plan’s Benefits Chart** (this chart is in Chapter 4 of this booklet).
- **The care you receive is considered medically necessary.** “Medically necessary” means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

- **You have a network Primary Care Physician (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).
 - In most situations, your network PCP must give you approval in advance before you can use other providers in the plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a "referral." For more information about this, see Section 2.3 of this chapter.
 - Referrals from your PCP are not required for emergency care or urgently needed care. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.2 of this chapter).
- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. *Here are three exceptions:*
 - The plan covers emergency care or urgently needed care that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed care means, see Section 3 in this chapter.
 - If you need medical care that Medicare or MassHealth Standard (Medicaid) requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider upon a referral from your PCP. In this situation, we will cover these services at no cost to you. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.
 - Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area.

SECTION 2 Use providers in the plan's network to get your medical care and other services

Section 2.1 You must choose a Primary Care Physician (PCP) to provide and oversee your care

What is a "PCP" and what does the PCP do for you?

When you become a member of our Plan, you must choose a network provider to be your PCP. Your PCP is a physician who meets state requirements and is trained to give you basic medical care. As we explain below, you will get your routine or basic care from your PCP. Your PCP will also coordinate the rest of the covered services you get as a member of our Plan.

What types of providers may act as a PCP?

Generally, Internal Medicine, General Medicine, or Family Practitioners act as PCPs.

How do you get care from your PCP?

You will usually see your PCP first for most of your health care needs. Your PCP will provide most of your care and will help arrange or coordinate the rest of the covered services you get as a plan member. This includes your x-rays, laboratory tests, therapies, care from doctors who are specialists, hospital admissions, and follow-up care.

Sometimes you may need to talk with your Primary Care Physician (PCP) or get medical care when your PCP's office is closed. If you have a non-emergency situation and need to talk to your PCP after hours, you can call your PCP's office at any time and there will be a physician on call to help you. Hearing or speech-impaired members with TTY machines can call the Massachusetts Relay Association at TTY 1-800-439-2370 for assistance contacting your PCP after hours (the non-TTY number for the Massachusetts Relay Association is 1-800-439-0183).

What is the role of the PCP in coordinating covered services?

“Coordinating” your services includes checking or consulting with other plan providers about your care. If you need certain types of covered services or supplies, your PCP may refer you to a specialist. **Each plan PCP has certain plan specialists called a “referral circle” that s/he uses for providing medical care to you.** A referral circle is the team of specialists your PCP works with. If your PCP refers you to a specialist s/he will send you to a specialist in his/her referral circle. Not all Tufts Health Plan physicians are included in your PCP's referral circle. This means that in most cases, you will not have access to the entire Tufts Health Plan network, except in emergency or urgent care situations or for out-of-area renal dialysis or other services. Also, your PCP's referral may be time limited. In some cases, your PCP will need to get prior authorization (prior approval) from us. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office.

What is the role of the PCP in making decisions about or obtaining prior authorization?

Certain drugs, equipment, and supplies require authorization from Tufts Health Plan Senior Care Options prior to services being rendered. For out-of-network services, your PCP is responsible for obtaining an authorization or providing you with a referral depending on the services being rendered. Your PCP or other network provider is responsible for obtaining this authorization. Please be sure to check with your PCP or other network provider to be sure this authorization or referral has been provided.

How do you choose your PCP?

When you are deciding on a PCP, you may refer to our *Provider Directory*. Once you have made a choice, you should call Customer Relations (see the number on the front of this booklet). A Customer Relations representative will verify that the PCP you have chosen is in the network. If you are making a change, the change will be effective the 1st of the following month, and you will automatically receive a new member ID card in the mail reflecting this change. If you are to be admitted to a particular hospital, check the *Provider Directory*, or speak with a Customer Relations representative to be sure your PCP of choice uses that hospital.

Changing your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP.

To change your PCP, call Customer Relations. They will also check to be sure the PCP you want to switch to is in the network and accepting new patients. ***If the PCP is in the network and accepting new patients, you will be able to make an appointment with your new PCP beginning the first of the following month.*** Customer Relations will change your membership record to show the name of your new PCP, and will send you a new membership card that shows the name and phone number of your new PCP. We suggest that you make an appointment with, and arrange for your records to be transferred to your new PCP.

Section 2.2	What kinds of medical care and other services can you get without getting approval in advance from your PCP?
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You can get services such as those listed below without getting approval in advance from your PCP.

- Routine women's health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Flu shots, Hepatitis B vaccinations, and pneumonia vaccinations as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed care from in-network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible, e.g., when you are temporarily outside of the plan's service area.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. (If possible, please call Customer Relations before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away. Phone numbers for Customer Relations are printed on the back cover of this booklet.)
- Routine dental care provided by a network dentist.

- Medicare-covered preventive services as long as you get them from a network provider.

Section 2.3 How to get care from specialists and other network providers

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart conditions.
- Orthopedists care for patients with certain bone, joint, or muscle conditions.

What is the role of the PCP in referring members to specialists and other providers?

Generally, PCPs provide basic preventive care and treatment for common illnesses. For services your PCP can't provide, he/she will help arrange or coordinate the rest of the covered services you get as a plan member by referring you to a specialist.

For what services will the PCP need to get prior authorization from the plan?

Certain drugs, equipment, and supplies require authorization from Tufts Health Plan Senior Care Options prior to services being rendered. For out-of-network services, your PCP is responsible for obtaining an authorization or providing you with a referral depending on the services being rendered. Your PCP or other network provider is responsible for obtaining this authorization. Please be sure to check with your PCP or other network provider to be sure this authorization or referral has been provided.

For information about which services require prior authorization from the Plan, see Chapter 4, Section 2.1. Services that require prior authorization are noted with an asterisk in the Medical Benefits Chart in Chapter 4. You can also call Customer Relations at the number on the back of this booklet for a list of services requiring your PCP or other network provider to obtain prior authorizations from the Plan. Please refer to your Tufts Health Plan Senior Care Options Formulary for drugs that require prior authorization.

What is a "referral circle"?

Each plan PCP has certain plan specialists called a "referral circle" that she or he uses for providing medical care to you. This means that in most cases, you will not have access to the entire Tufts Health Plan Senior Care Options network, except in emergency or urgent care situations or for out-of-area renal dialysis or other services.

If you need certain types of covered services or supplies, your PCP must give approval in advance (such as referring you to a specialist). In some cases, your PCP will also need to get prior authorization (prior approval) from the Plan. Services that require prior authorization are noted with an asterisk in the Medical Benefits Chart in Chapter 4. Services that require a referral

are noted within the Medical Benefits Chart in Chapter 4. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office.

What if a specialist or another network provider leaves our plan?

We may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan but if your doctor or specialist does leave your plan you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- When possible we will provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan please contact us so we can assist you in finding a new provider and managing your care.

Customer Relations can help with questions or assistance in finding and selecting another provider (Customer Relations phone numbers are printed on the back cover of this booklet).

Section 2.4	How to get care from out-of-network providers
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Your PCP or network provider will provide a referral for you to see an out-of-network provider if no network provider is available. You or your authorized representative may also submit a request to Tufts Health Plan Senior Care Options. Authorization from Tufts Health Plan Senior Care Options may be required based on the service to be rendered. If you use out-of-network providers without a referral or authorization, payment will not be made by Tufts Health Plan Senior Care Options. See Chapter 4 for more information.

SECTION 3 How to get covered services when you have an emergency or urgent need for care

Section 3.1 Getting care if you have a medical emergency
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What is a “medical emergency” and what should you do if you have one?

A “**medical emergency**” is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Please call Customer Relations at 1-855-670-5934 Monday – Friday, 8:00 a.m. – 8:00 p.m. (From Oct. 1 – Feb. 14 representatives are available 7 days a week, 8:00 a.m. – 8:00 p.m.) to notify us of your emergency.

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the Benefits Chart in Chapter 4 of this booklet.

For information on worldwide coverage for emergencies, see the medical benefits chart in Chapter 4.

If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by our plan. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all. If it turns out that it was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor has said that it was *not* an emergency, we will cover additional care *only* if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care.
- – *or* – the additional care you get is considered “urgently needed care” and you follow the rules for getting this urgent care (for more information about this, see Section 3.2 below).

Section 3.2 Getting care when you have an urgent need for care

What is “urgently needed care”?

“Urgently needed care” is a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed care may be furnished by in-network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have.

What if you are in the plan's service area when you have an urgent need for care?

In most situations, if you are in the plan's service area, we will cover urgently needed care *only* if you get this care from a network provider and follow the other rules described earlier in this chapter. However, if the circumstances are unusual or extraordinary, and network providers are temporarily unavailable or inaccessible, we will cover urgently needed care that you get from an out-of-network provider.

If you believe you are experiencing an urgent, unforeseen, non-emergency medical situation, please contact your PCP immediately. If you are unable to do so, or if it is impractical for you to receive care with your PCP or a network provider, you can go to any provider or clinic that provides urgently needed care, or you can dial 911 for immediate help.

What if you are outside the plan's service area when you have an urgent need for care?

When you are outside the service area and cannot get care from a network provider, our plan will cover urgently needed care that you get from any provider.

Our plan covers urgently needed care worldwide.

SECTION 4 What if you are billed directly for the full cost of your covered services?

Section 4.1 You can ask us to pay for covered services
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If you have paid for your covered services, or if you have received a bill for covered medical services, go to Chapter 6 (*Asking us to pay a bill you have received for covered medical services or drugs*) for information about what to do.

Section 4.2 What should you do if services are not covered by our plan?

Tufts Health Plan Senior Care Options covers all medical services that are medically necessary, are listed in the plan's Benefits Chart (this chart is in Chapter 4 of this booklet), and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan covered services, or they were obtained out-of-network and were not authorized.

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

Chapter 8 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Customer Relations to get more information about how to do this (phone numbers are printed on the back cover of this booklet).

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. You can call Customer Relations when you want to know how much of your benefit limit you have already used.

SECTION 5 How are your medical services covered when you are in a "clinical research study"?

Section 5.1 What is a "clinical research study"?
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A clinical research study (also called a "clinical trial") is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Not all clinical research studies are open to members of our plan. Medicare first needs to approve the research study. If you participate in a study that Medicare has *not* approved, *you will be responsible for paying all costs for your participation in the study.*

Once Medicare approves the study, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study *and* you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in a Medicare-approved clinical research study, you do *not* need to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers.

Although you do not need to get our plan's permission to be in a clinical research study, **you do need to tell us before you start participating in a clinical research study.** Here is why you need to tell us:

1. We can let you know whether the clinical research study is Medicare-approved.
2. We can tell you what services you will get from clinical research study providers instead of from our plan.

If you plan on participating in a clinical research study, contact Customer Relations (phone numbers are printed on the back cover of this booklet).

Section 5.2	When you participate in a clinical research study, who pays for what?
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Once you join a Medicare-approved clinical research study, you are covered for routine items and services you receive as part of the study, including:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure if it is part of the research study.
- Treatment of side effects and complications of the new care.

Original Medicare pays most of the cost of the covered services you receive as part of the study. After Medicare has paid its share of the cost for these services, our plan will pay the rest. Like for all covered services, you will pay nothing for the covered services you get in the clinical research study.

In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the study. Please see Chapter 6 for more information about submitting requests for payment.

When you are part of a clinical research study, **neither Medicare nor our plan will pay for any of the following:**

- Generally, Medicare will *not* pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were *not* in a study.
- Items and services the study gives you or any participant for free.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.

Do you want to know more?

You can get more information about joining a clinical research study by reading the publication “Medicare and Clinical Research Studies” on the Medicare website (<http://www.medicare.gov>). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 6 Rules for getting care covered in a “religious non-medical health care institution”

Section 6.1	What is a religious non-medical health care institution?
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A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility care. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. You may choose to pursue medical care at any time for any reason. This benefit is provided only for Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

Section 6.2	What care from a religious non-medical health care institution is covered by our plan?
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To get care from a religious non-medical health care institution, you must sign a legal document that says you are conscientiously opposed to getting medical treatment that is “non-excepted.”

- “Non-excepted” medical care or treatment is any medical care or treatment that is *voluntary* and *not required* by any federal, state, or local law.

- “Excepted” medical treatment is medical care or treatment that you get that is *not* voluntary or *is required* under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in your home, our plan will cover these services only if your condition would ordinarily meet the conditions for coverage of services given by home health agencies that are not religious non-medical health care institutions.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
 - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
 - – *and* – you must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.
 - Medicare coverage limits apply as described in Chapter 4 under ‘Inpatient Hospital Care’.

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1	Will you own the durable medical equipment after making a certain number of payments under our plan?
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Durable medical equipment includes items such as oxygen equipment and supplies, wheelchairs, walkers, and hospital beds ordered by a provider for use in the home. Certain items, such as prosthetics, are always owned by the member. In this section, we discuss other types of durable medical equipment that must be rented.

In Original Medicare, people who rent certain types of durable medical equipment own the equipment after paying copayments for the item for 13 months. As a member of Tufts Health Plan Senior Care Options, however, you usually will not acquire ownership of rented durable medical equipment. Under certain limited circumstances we will transfer ownership of the durable medical equipment item. Call Customer Relations (phone numbers are printed on the back cover of this booklet) to find out about the requirements you must meet and the documentation you need to provide.

What happens to payments you have made for durable medical equipment if you switch to Original Medicare?

If you switch to Original Medicare after being a member of our plan: If you did not acquire ownership of the durable medical equipment item while in our plan, you will have to make 13 new consecutive payments for the item while in Original Medicare in order to acquire ownership of the item. Your previous payments while in our plan do not count toward these 13 consecutive payments.

If you made payments for the durable medical equipment item under Original Medicare *before* you joined our plan, these previous Original Medicare payments also do not count toward the 13 consecutive payments. You will have to make 13 consecutive payments for the item under Original Medicare in order to acquire ownership. There are no exceptions to this case when you return to Original Medicare.

Chapter 4. Benefits Chart (what is covered)

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SECTION 1 Understanding covered services

This chapter focuses on what services are covered. It includes a Benefits Chart that lists your covered services as a member of Tufts Health Plan Senior Care Options. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

Section 1.1 You pay nothing for your covered services

Because you get assistance from MassHealth Standard (Medicaid), you pay nothing for your covered services as long as you follow the plans' rules for getting your care. (See Chapter 3 for more information about the plans' rules for getting your care.)

Section 1.2 What is the most you will pay for Medicare Part A and Part B covered medical services?
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Note: Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.

SECTION 2 Use the *Benefits Chart* to find out what is covered for you

Section 2.1 Your medical long-term care or home and community-based services benefits as a member of the plan

The Benefits Chart on the following pages lists the services Tufts Health Plan Senior Care Options covers. The services listed in the Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare and MassHealth Standard (Medicaid) covered services must be provided according to the coverage guidelines established by Medicare and MassHealth Standard (Medicaid).
- Your services (including medical care, services, supplies, and equipment) *must* be medically necessary. “Medically necessary” means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered. Chapter 3 provides more information about requirements for using network providers and the situations when we will cover services from an out-of-network provider.
- You have a Primary Care Physician (a PCP) who is providing and overseeing your care.

In most situations, your PCP must give you approval in advance before you can see other providers in the plan's network. This is called giving you a "referral." Chapter 3 provides more information about getting a referral and the situations when you do not need a referral.

- Some of the services listed in the Benefits Chart are covered *only* if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us. Covered services that need approval in advance are marked in the Benefits Chart by an asterisk.

Other important things to know about our coverage:


- Like all Medicare health plans, we cover everything that Original Medicare covers. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2015 Handbook*. View it online at <http://www.medicare.gov> or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you.
- Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2015, either Medicare or our plan will cover those services.




You do not pay anything for the services listed in the Benefits Chart, as long as you meet the coverage requirements described above.








You will see this apple next to the preventive services in the benefits chart.

Benefits Chart

Services that are covered for you	What you must pay when you get these services
<p> Abdominal aortic aneurysm screening</p> <p>A one-time screening ultrasound for people at risk. The plan only covers this screening if you get a referral for it as a result of your “Welcome to Medicare” preventive visit.</p>	<p>There is no coinsurance, copayment, or deductible for beneficiaries eligible for this preventive screening.</p>
<p>Acupuncture</p> <p>One evaluation and up to 12 treatment visits per year when provided by a licensed acupuncturist, not to exceed \$500 per calendar year.</p> <p>Other modalities are not covered.</p> <p>To obtain up to the \$500 Acupuncture reimbursement please submit a claim form along with an itemized bill from the licensed acupuncturist and paid receipts. Call Customer Relations to request a claim form or go to our website http://thpmp.org/sco. Send the completed claim form, along with the paid receipts, to Customer Relations at the address shown on the claim form</p>	<p>Plan reimburses you up to \$500 per calendar year towards one evaluation and 12 treatment visits per calendar year by a licensed acupuncturist.</p> <p>Reimbursement requests must be received by Tufts Health Plan Senior Care Options by no later than March 31st of the following year.</p>
<p>Ambulance services</p> <ul style="list-style-type: none">• Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation are contraindicated (could endanger the person’s health) or if authorized by the plan.• Non-emergency transportation by ambulance is appropriate if it is documented that the member’s condition is such that other means of transportation are contraindicated (could endanger the person’s health) and that transportation by ambulance is medically required.	<p>You pay \$0 for covered services</p>

Services that are covered for you	What you must pay when you get these services
<p> Annual wellness visit</p> <p>If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months.</p> <p>Note: Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.</p>	<p>There is no coinsurance, copayment, or deductible for the annual wellness visit.</p>
<p> Bone mass measurement</p> <p>For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.</p>	<p>There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.</p>
<p> Breast cancer screening (mammograms)</p> <p>Covered services include:</p> <ul style="list-style-type: none">• One baseline mammogram between the ages of 35 and 39• One screening mammogram every 12 months for women age 40 and older• Clinical breast exams once every 24 months	<p>There is no coinsurance, copayment, or deductible for covered screening mammograms.</p>
<p>Cardiac rehabilitation services</p> <p>Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.</p>	<p>You pay \$0 for covered services</p>

Services that are covered for you	What you must pay when you get these services
<p> Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)</p> <p>We cover 1 visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating well.</p>	<p>There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.</p>
<p> Cardiovascular disease testing</p> <p>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).</p>	<p>There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.</p>
<p> Cervical and vaginal cancer screening</p> <p>Covered services include:</p> <ul style="list-style-type: none">• For all women: Pap tests and pelvic exams are covered once every 24 months• If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months	<p>There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.</p>
<p>Chiropractic services</p> <p>Covered services include:</p> <ul style="list-style-type: none">• We cover only manual manipulation of the spine to correct subluxation <p>See “Additional MassHealth Standard (Medicaid) Covered Benefits” on page 81</p>	<p>You pay \$0 for covered services</p> <p>Before you receive services you must first obtain a referral from your PCP.</p>

Services that are covered for you	What you must pay when you get these services
<p> Colorectal cancer screening</p> <p>For people 50 and older, the following are covered:</p> <ul style="list-style-type: none">• Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months• Fecal occult blood test, every 12 months <p>For people at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none">• Screening colonoscopy (or screening barium enema as an alternative) every 24 months <p>For people not at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none">• Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy	<p>There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.</p>
<p>Dental services</p> <p>In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover: Medicare Covered services by a dentist or oral surgeon that are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor</p> <p>See “Additional MassHealth Standard (Medicaid) Covered Benefits” on page 81.</p>	<p>You pay \$0 for covered services</p>
<p> Depression screening</p> <p>We cover 1 screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and referrals.</p>	<p>There is no coinsurance, copayment, or deductible for an annual depression screening visit.</p>

Services that are covered for you


What you must pay when you get these services

 **Diabetes screening**

We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes.

Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.

There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.

Services that are covered for you	What you must pay when you get these services
<p> Diabetes self-management training, diabetic services and supplies</p> <p>For all people who have diabetes (insulin and non-insulin users). Covered services include:</p> <ul style="list-style-type: none">• Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.• For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.• Diabetes self-management training is covered under certain conditions.	<p>You pay \$0 for covered services</p> <p>You must first obtain a prescription from your PCP or physician treating your diabetes for covered diabetic supplies (including therapeutic custom-molded shoes).</p> <p>Before you receive diabetes self-management training you must first obtain a referral from your PCP</p>
<p>Additional Item covered by Tufts Health Plan Senior Care Options: Additional Pair of Therapeutic custom-molded shoes.</p> <ul style="list-style-type: none">• Tufts Health Plan Senior Care Options provides coverage for an additional pair of therapeutic, custom-molded shoes for members who have severe diabetic foot disease and meet the requirements as defined by Medicare.	<p>You pay \$0 for covered services</p>

Services that are covered for you	What you must pay when you get these services
<p>Durable medical equipment and related supplies* (For a definition of “durable medical equipment,” see Chapter 11 of this booklet.)</p> <p>Covered items include, but are not limited to: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker.</p> <p>We cover all medically necessary durable medical equipment covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you.</p>	<p>You pay \$0 for covered services</p>
<p>Emergency care</p> <p>Emergency care refers to services that are:</p> <ul style="list-style-type: none">• Furnished by a provider qualified to furnish emergency services, and• Needed to evaluate or stabilize an emergency medical condition. <p>A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.</p> <p>Your plan includes worldwide coverage for emergency care.</p>	<p>You pay \$0 for covered services</p> <p>If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan.</p>

* Except in an emergency, prior authorization from Tufts Health Plan Senior Care Options may be required before you obtain certain durable medical equipment and related supplies.

Services that are covered for you

What you must pay when you get these services

 **Health and wellness education programs**

Adult Immunization Programs

- Annual flu vaccine reminder call

You pay \$0 for this program

Wellness Allowance

Exercise classes and fitness clubs


- Participation in instructional fitness classes such as yoga, Pilates, Tai Chi and aerobics.
- Membership in a qualified health club or fitness facility. A qualified health club or fitness facility provides cardiovascular and strength training exercise equipment on site. This benefit does not cover membership fees you pay to non-qualified health clubs or fitness facilities, including but not limited to, martial arts centers; gymnastics facilities; country clubs, sports clubs and social clubs; and for sports activities such as golf and tennis.
- Visits to a licensed nutritional counselor or registered dietician for nutritional counseling services

Plan reimburses you up to \$200 each calendar year towards your cost for membership in a qualified health club or fitness facility, covered instructional fitness classes, participation in Matter of Balance programs, use of a Chronic Disease Self-Management Program, participation in the Diabetes Workshop program, Healthy Eating for Successful Living program, Healthy IDEAs program, Powerful Tools for Caregivers program, Arthritis Foundation Exercise program, Enhance Wellness program, Fit For Your Life program, AAA Senior Driving program, and/or covered nutritional counseling sessions with a licensed nutritional counselor or registered dietician. You pay all charges over \$200 per

Wellness Programs

- Participation in a certified instructor led “Matter of Balance” program
- Participation in a Chronic Disease Self-Management Program
- Visits to a licensed nutritional counselor or registered dietician for nutritional counseling services
- Participation in the Diabetes Workshop program
- Participation in the Healthy Eating for Successful Living program
- Participation in the Healthy IDEAs program
- Participation in the Powerful Tools for Caregivers program
- Participation in the Arthritis Foundation Exercise program
- Participation in the Enhance Wellness program including

Services that are covered for you	What you must pay when you get these services
<p>memory fitness activities</p> <ul style="list-style-type: none">• Participation in the Fit for Your Life program• Participation in the AAA Senior Driving program <p>To obtain up to the \$200 Wellness Allowance reimbursement please submit a Wellness benefit claim form along with an itemized bill from the qualified facility, licensed nutritional counselor or registered dietician and paid receipts. Call Customer Relations to request a claim form or go to our Web site http://www.thmp.org/sco. Send the completed claim form, along with the paid receipts, to Customer Relations at the address shown on the claim form.</p>	<p>calendar year.</p> <p>Reimbursement requests for a prior year must be received by Tufts Health Plan Senior Care Options no later than March 31 of the following year.</p> <p>No referral is required for this benefit.</p>
<p><u>Weight Management Programs</u></p> <p>The Plan will cover program fees for weight loss programs such as WeightWatchers, Jenny Craig, Nutrisystem, or a hospital-based weight loss program. This benefit does not cover costs for pre-packaged meals/foods, books, videos, scales, or other items or supplies.</p> <p>To obtain up to the \$200 Weight Management Programs reimbursement please submit a claim form along with an itemized bill from the qualified weight management program and paid receipts. Call Customer Relations to request a claim form or go to our Web site http://www.thmp.org/sco. Send the completed claim form, along with the paid receipts, to Customer Relations at the address shown on the claim form.</p>	<p>The Plan will reimburse members up to an annual maximum of \$200 towards program fees for weight loss programs.</p> <p>Reimbursement requests must be received by Tufts Health Plan Senior Care Options by no later than March 31st of the following year.</p>

Services that are covered for you	What you must pay when you get these services
<p>Hearing services</p> <p>Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.</p> <ul style="list-style-type: none">• Diagnostic hearing exams• Routine hearing test every calendar year <p>See “Additional MassHealth Standard (Medicaid) Covered Benefits” on page 81.</p>	<p>You pay \$0 for covered services</p> <p>Before you receive a diagnostic hearing exam from a specialist you must first obtain a referral from your PCP.</p> <p>No referral is required for an annual routine hearing test, but you must use a Plan provider.</p>
<p> HIV screening</p> <p>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:</p> <ul style="list-style-type: none">• One screening exam every 12 months <p>For women who are pregnant, we cover:</p> <ul style="list-style-type: none">• Up to three screening exams during a pregnancy	<p>There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered preventive HIV screening.</p>

Services that are covered for you	What you must pay when you get these services
<p>Home health agency care</p> <p>Prior to receiving home health services, a doctor must certify that you have a skilled need and order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort.</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none">• Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and fewer than 35 hours per week)• Physical therapy, occupational therapy, and speech therapy• Medical and social services• Medical equipment and supplies <p>Home infusion therapy* provided in the home by a home infusion therapy provider when your prescription is written by an authorized prescriber and administered in accordance with Plan guidelines.</p> <p>Covered services include certain intravenous medications, biologicals, intrathecal and epidural infusions, and total parenteral nutrition formulas, and the necessary supplies, equipment and skilled nursing visits to administer these services.</p> <p>Tufts Health Plan Senior Care Options covers the following Part D home infusion drugs as part of a bundled service under the home infusion benefit: intravenous antibiotics and intravenous immunoglobulins.</p>	<p>You pay \$0 for Medicare-covered home health care services, including home infusion therapy services.</p>

* Except in an emergency, prior authorization from Tufts Health Plan Senior Care Options is required before you get this service.

Services that are covered for you

What you must pay when you get these services

Hospice care

You may receive care from any Medicare-certified hospice program. Your hospice doctor can be a network provider or an out-of-network provider.

Covered services include:

- Drugs for symptom control and pain relief
- Short-term respite care
- Home care

For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal condition: Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal condition. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for.

For services that are covered by Medicare Part A or B and are not related to your terminal condition: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal condition, your cost for these services depends on whether you use a provider in our plan's network:

- If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services
- If you obtain the covered services from an out-of-network provider, you pay the cost-sharing under Fee-for-Service Medicare (Original Medicare)


For services that are covered by Tufts Health Plan Senior Care Options but are not covered by Medicare Part A or B: Tufts Health Plan Senior Care Options will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal condition. You pay your plan cost-sharing amount for these services.

For drugs that may be covered by the plan's Part D benefit:

Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.3 (*What if you're in Medicare-certified hospice*).

Note: If you need non-hospice care (care that is not related to your terminal condition), you should contact us to arrange the services. Getting your non-hospice care through our network providers will lower your share of the costs for the services.

When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal condition are paid for by Original Medicare, not Tufts Health Plan Senior Care Options.

Services that are covered for you	What you must pay when you get these services
<p> Immunizations</p> <p>Covered Medicare Part B services include:</p> <ul style="list-style-type: none">• Pneumonia vaccine• Flu shots, once a year in the fall or winter• Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B• Other vaccines if you are at risk and they meet Medicare Part B coverage rules <p>We also cover some vaccines under our Part D prescription drug benefit.</p>	<p>There is no coinsurance, copayment, or deductible for the pneumonia, influenza, and Hepatitis B vaccines.</p>
<p>Inpatient hospital care</p> <p>Includes inpatient acute, inpatient rehabilitation, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.</p> <p><u>For care in a general acute care hospital</u>, you are covered for as many days as medically necessary: there is no limit. Medicare benefit periods do not apply to acute hospital stays.</p> <p><u>For care in a rehabilitation or long-term acute care hospital</u> you are covered up to 90 days each benefit period. You may use your 60-lifetime reserve days to supplement care in a rehabilitation or long-term hospital. Coverage is limited by prior, partial, or complete use of these days, which may only be used once in a lifetime.</p> <p>Covered services include but are not limited to:</p> <ul style="list-style-type: none">• Semi-private room (or a private room if medically necessary)• Meals including special diets• Regular nursing services• Costs of special care units (such as intensive care or coronary care units)• Drugs and medications• Lab tests	<p>You pay \$0 for covered services</p> <p>If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.</p>

Services that are covered for you


What you must pay when you get these services

- X-rays and other radiology services
- Necessary surgical and medical supplies
- Use of appliances, such as wheelchairs
- Operating and recovery room costs
- Physical, occupational, and speech language therapy
- Inpatient substance abuse services
- Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Original Medicare rate, then you can choose to obtain your transplant services locally or at a distant location offered by the plan. If Tufts Health Plan Senior Care Options provides transplant services at a distant location (outside of the service area) and you chose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion.
- Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first three pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used.
- Physician services


Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.

You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at <http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf> or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.

Services that are covered for you	What you must pay when you get these services
<p>Inpatient mental health care</p> <ul style="list-style-type: none">• Covered services include mental health care services that require a hospital stay. Medicare covers up to 90 days per benefit period with a limit of up to 190 days of inpatient psychiatric hospital care in a lifetime. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital.• For inpatient mental health/substance abuse services, you will be required to use the hospital within your Primary Care Physician's (PCP's) referral circle designated for mental health services. This may require a transfer from the hospital your PCP uses for medical and surgical services to the facility designated for mental health services.	<p>You pay \$0 for covered services</p>
<p>Inpatient services covered during a non-covered inpatient stay</p> <p>If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include but are not limited to:</p> <ul style="list-style-type: none">• Physician services• Diagnostic tests (like lab tests)• X-ray, radium, and isotope therapy including technician materials and services• Surgical dressings• Splints, casts and other devices used to reduce fractures and dislocations• Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices• Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition• Physical therapy, speech therapy, and occupational therapy	<p>You pay \$0 for covered services</p>

Services that are covered for you	What you must pay when you get these services
<p> Medical nutrition therapy</p> <p>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor.</p> <p>We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.</p>	<p>There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered medical nutrition therapy services.</p>
<p>Medicare Part B prescription drugs *</p> <p>These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include:</p> <ul style="list-style-type: none">• Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services• Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan• Clotting factors you give yourself by injection if you have hemophilia• Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant• Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug• Antigens• Certain oral anti-cancer drugs and anti-nausea drugs• Certain drugs for home dialysis, including heparin, the	<p>You pay \$0 for covered services</p>

* Except in an emergency, prior authorization from Tufts Health Plan Senior Care Options may be required before you obtain certain Medicare Part B Prescription Drugs.


Services that are covered for you	What you must pay when you get these services
<p>antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa)</p> <ul style="list-style-type: none">• Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases <p>Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered.</p>	
<p> Obesity screening and therapy to promote sustained weight loss</p> <p>If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.</p>	<p>There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.</p>
<p>Outpatient diagnostic tests and therapeutic services and supplies</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none">• X-rays• Radiation (radium and isotope) therapy including technician materials and supplies• Diagnostic radiology services, such as ultrasound, PET, MRI, and CT scan• Chemotherapy• Surgical supplies, such as dressings• Splints, casts and other devices used to reduce fractures and dislocations• Laboratory tests• Blood. Coverage begins with the fourth pint of blood that you need – you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. Coverage of storage and administration begins with the first pint of blood that you need.• Other outpatient diagnostic tests Includes but not limited to	<p>You pay \$0 for covered services</p>

Services that are covered for you	What you must pay when you get these services
sleep studies, EKG, stress tests, vascular studies, and breathing capacity tests.	
<p>Outpatient hospital services</p> <p>We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none">• Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery• Laboratory and diagnostic tests billed by the hospital• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it• X-rays and other radiology services billed by the hospital• Medical supplies such as splints and casts• Certain screenings and preventive services• Certain drugs and biologicals that you can't give yourself <p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	<p>You pay \$0 for covered services</p> <p>Before you receive services you must first obtain a referral from your PCP.</p>

Services that are covered for you	What you must pay when you get these services
<p>Outpatient mental health care</p> <p>Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.</p>	<p>You pay \$0 for covered services</p> <p>Before you receive services you must first obtain a referral from your PCP.</p>
<p>Outpatient rehabilitation services</p> <p>Covered services include: physical therapy, occupational therapy, and speech language therapy.</p> <p>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).</p>	<p>You pay \$0 for covered services</p> <p>Before you receive services you must first obtain a referral from your PCP.</p>
<p>Outpatient substance abuse services</p> <p>Coverage under Medicare Part B is available for treatment services that are provided in the outpatient department of a hospital to patients who, for example, have been discharged from an inpatient stay for the treatment of substance abuse or who require treatment but do not require the availability and intensity of services found only in the inpatient hospital setting.</p> <p>The coverage available for these services is subject to the same rules generally applicable to the coverage of outpatient hospital services.</p>	<p>You pay \$0 for covered services</p> <p>Before you receive services you must first obtain a referral from your PCP.</p>



Services that are covered for you	What you must pay when you get these services
<p>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</p> <p>Note: If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an “outpatient.”</p>	<p>You pay \$0 for covered services</p> <p>Before you receive services you must first obtain a referral from your PCP.</p>
<p>Partial hospitalization services</p> <p>“Partial hospitalization” is a structured program of active psychiatric treatment provided in a hospital outpatient setting or by a community mental health center, that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.</p>	<p>You pay \$0 for covered services</p>

Services that are covered for you	What you must pay when you get these services
<p>Physician/Practitioner services, including doctor's office visits</p> <p>Covered services include:</p> <ul style="list-style-type: none">• Medically-necessary medical care or surgery services furnished in a physician's office, hospital outpatient department, or any other location• Consultation, diagnosis, and treatment by a specialist• Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment• Certain telehealth services including consultation, diagnosis, and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare• Second opinion by another network provider prior to surgery• Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)• Annual Physical Exam (a more comprehensive examination than an annual wellness visit. Services will include the following: bodily systems examinations, such as heart, lung, head and neck, and neurological system; measurement and recording of vital signs such as blood pressure, heart rate, and respiratory rate; a complete prescription medication review; and a review of any recent hospitalizations), once every 12 months.• Follow-up office visits following discharge from hospital, SNF, Community Mental Health Centers stay, outpatient observation, or partial hospitalization.	<p>You pay \$0 for covered services</p> <p>Before you receive services you must first obtain a referral from your PCP.</p>
<p>See "Additional MassHealth Standard (Medicaid) Covered Benefits" on page 81.</p>	

Services that are covered for you	What you must pay when you get these services
<p>Podiatry services</p> <p>Covered services include:</p> <ul style="list-style-type: none">• Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs).• Routine foot care for members with certain medical conditions affecting the lower limbs such as metabolic, neurological or peripheral vascular disease (narrowing or blocking of the arteries carrying blood to the arms and legs). <p>For foot care related to Diabetes, please see “Diabetes self-management training, diabetic services and supplies” in this benefits chart.</p>	<p>You pay \$0 for covered services</p> <p>Before you receive services you must first obtain a referral from your PCP.</p>
<p> Prostate cancer screening exams</p> <p>For men age 50 and older, covered services include the following - once every 12 months:</p> <ul style="list-style-type: none">• Digital rectal exam• Prostate Specific Antigen (PSA) test	<p>There is no coinsurance, copayment, or deductible for an annual PSA test.</p>


Services that are covered for you	What you must pay when you get these services
<p>Prosthetic devices and related supplies*</p> <p>Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see “Vision Care” later in this section for more detail.</p> <p>Medical Supplies</p> <p>Medically necessary items or other materials that are used once, and thrown away, or somehow used up. Includes but not limited to: catheters, gauze, surgical dressing supplies, bandages, sterile water, and tracheostomy supplies.</p>	<p>You pay \$0 for covered services</p>
<p>Pulmonary rehabilitation services</p> <p>Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.</p>	<p>You pay \$0 for covered services</p>

* Except in an emergency, prior authorization from Tufts Health Plan Senior Care Options may be required before you obtain certain Prosthetic devices and related supplies.

Services that are covered for you	What you must pay when you get these services
<p> Screening and counseling to reduce alcohol misuse</p> <p>We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent.</p> <p>If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.</p>
<p> Screening for sexually transmitted infections (STIs) and counseling to prevent STIs</p> <p>We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a Primary Care Physician. We cover these tests once every 12 months or at certain times during pregnancy.</p> <p>We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a Primary Care Physician and take place in a primary care setting, such as a doctor's office.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling to prevent STIs preventive benefit.</p>
<p>Services to treat kidney disease and conditions</p> <p>Covered services include:</p> <ul style="list-style-type: none">• Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime.• Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3)• Inpatient dialysis treatments (if you are admitted as an	<p>You pay \$0 for covered services</p>

Services that are covered for you	What you must pay when you get these services
<p>inpatient to a hospital for special care)</p> <ul style="list-style-type: none">• Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)• Home dialysis equipment and supplies• Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) <p>Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section below, “Medicare Part B prescription drugs.”</p>	

Services that are covered for you	What you must pay when you get these services
<p>Skilled nursing facility (SNF) care</p> <p>(For a definition of “skilled nursing facility care,” see Chapter 11 of this booklet. Skilled nursing facilities are sometimes called “SNFs.”)</p> <p>You are covered for up to 100 days each benefit period. No prior hospital stay is required. Covered services include but are not limited to:</p> <ul style="list-style-type: none">• Semiprivate room (or a private room if medically necessary)• Meals, including special diets• Skilled nursing services• Physical therapy, occupational therapy, and speech therapy• Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.)• Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need – you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used.• Medical and surgical supplies ordinarily provided by SNFs• Laboratory tests ordinarily provided by SNFs• X-rays and other radiology services ordinarily provided by SNFs• Use of appliances such as wheelchairs ordinarily provided by SNFs• Physician/Practitioner services <p>Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to get your care from a facility that isn’t a network provider, if the facility accepts our plan’s amounts for payment.</p> <ul style="list-style-type: none">• A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care).• A SNF where your spouse is living at the time you leave the hospital.	<p>You pay \$0 for covered services</p> <p>You are covered for up to 100 days each benefit period. No prior hospital stay is required.</p>

Services that are covered for you	What you must pay when you get these services
<p> Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)</p> <p><u>If you use tobacco, but do not have signs or symptoms of tobacco-related disease:</u> We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits.</p> <p><u>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:</u> We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period.. Each counseling attempt includes up to four face-to-face visits.</p> <ul style="list-style-type: none">• Smoking cessation telephonic counseling is also available through QuitWorks. <p>If you are ready to quit or are thinking about it, ask your doctor about QuitWorks, or visit www.makesmokinghistory.org, or call 1-800-QUIT-NOW (1-800-784-8669).</p> <ul style="list-style-type: none">• Check your Tufts Health Plan Senior Care Options formulary for covered smoking cessation agents.	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.</p>
<p>Urgently needed care</p> <p>Urgently needed care is care provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed care may be furnished by in-network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.</p> <p>Your plan includes worldwide coverage for urgently needed care</p> <p>See “Additional MassHealth Standard (Medicaid) Covered Benefits” on page 81.</p>	<p>You pay \$0 for covered services</p>

Services that are covered for you

What you must pay when you get these services

Vision care

Covered services include:

- Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts, but these exams are covered under the routine eye exam benefit below.
- For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year.
- One pair of standard therapeutic (prescription) eyeglasses with standard frames or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant (Tints, anti-reflective coating, U-V lenses or oversize lenses are covered only when deemed medically necessary by the treating physician).

You pay \$0 for each Medicare-covered outpatient visit for services to diagnose and/or treat a disease or condition of the eye.


You pay \$0 for an annual glaucoma screening if you are at high risk.

Before you receive services from an ophthalmologist for diagnosis and/or treatment of a medical condition of the eye, you must first obtain a referral from your PCP. No referral is required to see an optometrist.

You pay \$0 for one pair of Medicare-covered standard eyeglasses with standard frames or contact lenses after cataract surgery when obtained from a Plan vision provider. You will pay any cost over the Medicare allowed charge if you purchase upgraded frames. Replacement also covered

No referral is required for this service, but you must obtain covered eyewear from

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none">• One pair of standard therapeutic (prescription) eyeglasses every calendar year (includes one pair of standard frames and single vision, bifocal or trifocal lenses) or contact lenses per prescription change for Keratoconus, Anisometropia (more than 3.0 diopters), or high myopia (more than 7.0 diopters). If your prescription changes during the year, an additional pair of glasses or contacts will be covered for each change.	<p>a Plan provider.</p> <p>You pay \$0 for one pair of standard eyeglasses with standard frames or contact lenses for Keratoconus, Anisometropia or high myopia. You will pay any cost over the allowed charge.</p> <p>No referral is required for this service, but you must obtain covered eyewear from a Plan provider.</p>
<ul style="list-style-type: none">• One routine eye exam each calendar year	<p>You pay \$0 for an annual routine eye exam.</p> <p>No referral is required for an annual routine eye exam, but you must use a provider in the EyeMed Vision Care network.</p>
<ul style="list-style-type: none">• One pair of routine eyeglasses (prescription lenses and frames) or contact lenses every calendar year. If the glasses or contact lenses are purchased from a provider in the EyeMed network, the benefit is limited to \$150. Sale items are excluded, and this benefit cannot be combined with any other store discounts, coupons, or promotional codes.	<p>Plan pays up to \$150 each calendar year towards the full retail price (not sale price) you pay for routine prescription eyeglasses or contact lenses purchased from an <i>EyeMed</i> vision provider. The EyeMed provider will process the claim.</p> <p>If the cost of the glasses or contacts exceeds the benefit limit (\$150 in the EyeMed network), you are responsible for all additional charges.</p>

Services that are covered for you	What you must pay when you get these services
	<p>The annual benefit can be applied to eyeglasses OR contact lenses, but not both.</p> <p>The Plan provider for services, glasses or contacts for routine vision care may be different from the Plan provider of services, glasses, or contacts to treat the medical conditions described in the first four bullet points. Call Customer Relations if you have questions about your vision benefits.</p>
<p> “Welcome to Medicare” Preventive Visit</p> <p>The plan covers the one-time “Welcome to Medicare” preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed.</p> <p>Important: We cover the “Welcome to Medicare” preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor’s office know you would like to schedule your “Welcome to Medicare” preventive visit.</p>	<p>There is no coinsurance, copayment, or deductible for the “Welcome to Medicare” preventive visit.</p>
<p>Wigs</p> <p>Wigs are covered for members who experience hair loss due to treatment for cancer</p>	<p>Plan covers up to \$350 in a calendar year.</p> <p>If the cost of the wig exceeds the benefit limit (\$350), you are responsible for all additional charges. No referral is required for this benefit.</p>

Services that are covered for you	What you must pay when you get these services
Additional MassHealth Standard (Medicaid) Covered Benefits	
Adult Day Health and Transportation Services that may include nursing and health oversight, assistance with activities of daily living, nutritional and dietary services, counseling services, activities and transportation to an Adult Day Health site.	You pay \$0 for covered services
Adult Foster Care (AFC) AFC is for members who need daily help with personal care, but want to live in a family setting rather than in a nursing home or other facility. The caregiver provides meals, companionship, personal care assistance, and 24-hour supervision. AFC members live with trained paid caregivers who provide daily care. Caregivers may be individuals, couples, or larger families.	You pay \$0 for covered services
Group Adult Foster Care (GAFC) GAFC includes personal care services for eligible members with disabilities who live in GAFC-approved housing. Housing may be an assisted living residence or specially designated public or subsidized housing.	You pay \$0 for covered services
Chiropractic Services We cover up to 20 office visits or chiropractic manipulation treatments under the MassHealth Standard (Medicaid) benefit See “Benefits chart” on page 51.	You pay \$0 for covered services Before you receive services you must first obtain a referral from your PCP.

Services that are covered for you	What you must pay when you get these services
<p>Community-Based Services</p> <ul style="list-style-type: none">• Chore• Companion• Day habilitation• Grocery shopping and delivery• Homemaker• Home modification*• Home delivered meals• Laundry• Personal care services• Personal Emergency Response System (PERS)• Respite*• Social day care	<p>You pay \$0 for covered services</p> <p>Before you receive community-based services, you must first discuss these services with your Plan Care Manager. Prior authorization may be required for certain community-based services.</p>

* Except in an emergency, prior authorization from Tufts Health Plan Senior Care Options is required before you get this service.

Services that are covered for you	What you must pay when you get these services
<p>Dental Services</p> <p>We cover:</p> <ul style="list-style-type: none"> • Extractions (removing teeth), emergency care visits • Some oral surgery such as biopsies and soft-tissue surgery • Restorative (fillings) • Endodontic (root canal) • Periodontic (deep scaling) • Crowns • Dentures (full, partial, or repair) • Surgical procedures related to full or partial dentures • Diagnostic (X-rays and exams) preventive (cleanings) <p>Services must be performed by a DentaQuest provider. For more information, contact DentaQuest at 1-888-309-6508.</p> <p>See “Benefits chart” on page 51.</p>	<p>You pay \$0 for covered services</p> <p>Prior authorization required for certain dental services.</p> <ul style="list-style-type: none"> • Routine exam once every 6 months • Complete intraoral X-ray once every 3 years • Bitewing: every 6 months • Panoramic X-ray: once every 3 years • Crown: one every 5 years* • Inlay: not covered within 6 months of initial placement • Replacement Crown: not covered within 6 months of initial placement* • Endodontic therapy: one per lifetime per patient* • Apioectomy/periradicular surgery: one per lifetime per patient* • Gingivectomy or gingivoplasty: once every 3 years* • Periodontal scaling and root planing: once every 3 years* • Complete denture: one every 5 years

* Except in an emergency, prior authorization from Tufts Health Plan Senior Care Options is required before you get this service.

Services that are covered for you	What you must pay when you get these services
	<ul style="list-style-type: none"> • Partial denture: one every 5 years • Reline complete denture: one every 3 years* • Alveoplasty: once per lifetime per patient
<p>Geriatric Support Services Coordination (GSSC)</p> <p>In-home assessment and home-based services coordination provided by an ASAP GSSC.</p>	<p>You pay \$0 for covered services</p>
<p>Health/Wellness Education</p> <p>Covers:</p> <ul style="list-style-type: none"> • Written health education materials • Nutritional training • Nutritional benefits • Other wellness services <p>See “Benefits chart” on page 51.</p>	<p>You pay \$0 for covered services</p>
<p>Hearing services</p> <p>Coverage includes audiology exams and evaluations, diagnostic services, hearing aids or instruments, and services related to the care and maintenance of hearing aids or instruments.</p> <ul style="list-style-type: none"> • Diagnostic hearing exams • Routine hearing test every calendar year • Hearing aids, supplies, and repairs.* 	<p>You pay \$0 for covered services</p>

* Except in an emergency, prior authorization from Tufts Health Plan Senior Care Options is required before you get this service.

Services that are covered for you	What you must pay when you get these services
<p>No authorization required for exams, evaluations, or diagnostic services</p> <p>See “Benefits chart” on page 51.</p>	
<p>Inpatient Hospital Care</p> <p>We will cover inpatient hospital care not covered under the Medicare benefit because you have MassHealth Standard (Medicaid.)</p> <p>See “Benefits chart” on page 51.</p>	<p>You pay \$0 for covered services</p>
<p>Inpatient Mental Health</p> <p>We will cover days in excess of 90 days in a benefit period because you have MassHealth Standard (Medicaid). There is no benefit period or lifetime limit. Days in a psychiatric hospital in excess of 190 days will be covered.</p> <p>See “Benefits chart” on page 51.</p>	<p>You pay \$0 for covered services</p>
<p>Institutional Long term Nursing Home Care (custodial care)</p> <p>Non-skilled, personal care, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include care that most people do themselves, like using eye drops. In most cases, Medicare doesn’t pay for custodial care.</p>	<p>You pay \$0 for covered services</p>

Services that are covered for you	What you must pay when you get these services
<p>Outpatient Mental Health Care</p> <p>Covered services include:</p> <p>Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other mental health care professional as allowed under applicable state laws.</p> <p>See “Benefits chart” on page 51.</p>	<p>You pay \$0 for covered services</p> <p>Before you receive services you must first obtain a referral from your PCP.</p>
<p>Over-the-Counter (OTC) Medications</p> <p>Please see the MassHealth Standard (Medicaid) OTC Drug List for details.</p> <p>In addition to the MassHealth Standard (Medicaid) OTC Drug List, Tufts Health Plan Senior Care Options provides coverage for the following drugs under your Medicare benefit:</p> <ul style="list-style-type: none">-Methylsulfonylmethane (MSM)-Glucosamine/Chondroitin/MSM-Glucosamine/MSM-Chondroitin/MSM-Omega 3/Fish Oil <p>Non brand-name (generic) OTC medications will be dispensed unless otherwise approved by Tufts Health Plan Senior Care Options. See formulary.</p>	<p>You pay \$0 for covered services</p> <p>Before you receive services you must first obtain a prescription from your treating provider.</p>
<p>Personal Care Attendant (PCA)</p> <p>A consumer-directed program that allows members to hire PCAs to help with Activities of Daily Living (ADLs) such as mobility/transfers, medications, bathing or grooming, dressing or undressing, range of motion exercises, eating, toileting and with Instrumental Activities of Daily Living (IADLs) such as shopping, laundry, meal preparation, housekeeping.</p> <p>Does not cover recreation, babysitting, or vocational training, verbal prompting or cuing, or supervision.</p>	<p>You pay \$0 for covered services</p>

Services that are covered for you	What you must pay when you get these services
<p>Podiatry</p> <p>Routine foot care for members without medical conditions affecting the lower limbs under the MassHealth Standard (Medicaid) benefit.</p> <p>See “Benefits chart” on page 51.</p>	<p>You pay \$0 for covered services</p> <p>Before you receive services you must first obtain a referral from your PCP.</p>
<p>Substance abuse</p> <p>Certain 24-hour substance abuse treatment services for post medical detoxification defined as Level IIIB and Level IIIC by the Massachusetts Department of Public Health.</p> <p>See “Benefits chart” on page 51.</p>	<p>You pay \$0</p> <p>Before you receive services you must first obtain a referral from your PCP.</p>
<p>Tobacco Cessation Services</p> <p>Includes group or individual counseling if requested by your doctor.</p> <p>Nicotine replacement medicine including nicotine patches, gum, lozenges, and certain other medicines if prescribed by your doctor.</p> <p>See “Benefits chart” on page 51.</p>	<p>You pay \$0 for covered services</p>
<p>Transportation</p> <p>Non-emergent transportation to medical appointments*</p>	<p>You pay \$0 for covered services</p>
<p>Vision (routine and preventive)</p> <p>One routine eye exam each calendar year</p> <p>See “Benefits chart” on page 51.</p>	<p>You pay \$0 for covered services</p>

* Except in an emergency, prior authorization from Tufts Health Plan Senior Care Options is required before you get this service.

Services that are covered for you	What you must pay when you get these services
<p>Wander Response System</p> <p>Alert or alarm</p>	<p>You pay \$0 for covered services</p>
<p>Behavioral Health</p> <p>Inpatient Services</p> <ul style="list-style-type: none"> • Inpatient Mental Health Services • Detoxification <p>Diversiónary Services</p> <ul style="list-style-type: none"> • Community Support • Crisis Stabilization • Observation/Holding Beds • Psychiatric Day Treatment • Residential Substance Abuse Treatment • Structured Outpatient Addiction Programs <p>BH Emergency Services</p> <ul style="list-style-type: none"> • Emergency Screening Services • Medication Management Services • Short Term Crisis Counseling • Short Term Crisis Stabilization Services • Specialing Services <p>Outpatient Services</p> <ul style="list-style-type: none"> • Mental Health - evaluation, treatment, medication, consultation • Substance Abuse Services - counseling, diagnostic evaluation, medication visit 	<p>You pay \$0 for covered services</p> <p>Before you receive the following outpatient services you must first obtain a referral from your PCP:</p> <ul style="list-style-type: none"> • Mental health - evaluation, treatment, medication, consultation • Substance abuse services - counseling, diagnostic evaluation, medication visit <p>Before you receive the following Special</p>

Services that are covered for you	What you must pay when you get these services
<p>Special Procedures</p> <ul style="list-style-type: none">• Electroconvulsive Therapy• Psychological Neuropsychological Testing <p>See “Benefits chart” on page 51.</p>	<p>Procedures, you must first obtain a referral from your PCP:</p> <ul style="list-style-type: none">• Psychological Neuropsychological Testing

SECTION 3 What benefits are not covered by the plan?

Section 3.1 Benefits *not* covered by the plan (exclusions)

This section tells you what kinds of benefits are “excluded”. Excluded means that the plan doesn’t cover these benefits. In some cases, MassHealth Standard (Medicaid) covers items or services that are excluded by Medicare. For more information about MassHealth Standard (Medicaid) benefits, call Customer Relations (phone numbers are printed on the back cover of this booklet).

The list below describes some services and items that aren’t covered by the plan under any conditions and some that are excluded by the plan only under specific conditions. The list also tells you if the service or item is covered by the plan under MassHealth Standard (Medicaid).

We won’t pay for the excluded medical benefits listed in this section (or elsewhere in this booklet), and neither will Original Medicare or MassHealth Standard (Medicaid). The only exception: If a benefit on the exclusion list is found upon appeal to be a medical benefit that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 8, Section 6.3 in this booklet.)

In addition to any exclusions or limitations described in the Benefits Chart, or anywhere else in this *Evidence of Coverage*, **the following items and services aren’t covered under Original Medicare or by our plan:**

- Services considered not reasonable and necessary, according to the standards of Original Medicare, unless these services are listed by our plan as covered services.
- Experimental medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.) Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.

- Surgical treatment for morbid obesity, except when it is considered medically necessary and covered under Original Medicare.
- Private room in a hospital, except when it is considered medically necessary.
- Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.
- Fees charged by your immediate relatives or members of your household, except as allowed under your MassHealth Standard (Medicaid) benefit.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- Cosmetic surgery or procedures, unless because of an accidental injury or to improve a malformed part of the body. However, all stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
- Radial keratotomy, LASIK surgery, vision therapy and other low vision aids. However, eyeglasses are covered for people after cataract surgery, but excludes scratch resistant coatings, mirror coatings, polarized lenses, deluxe lens features and progressive lenses
- Reversal of sterilization procedures and non-prescription contraceptive supplies.
- Naturopath services (uses natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when emergency services are received at VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.

The plan will not cover the excluded services listed above. Even if you receive the services at an emergency facility, the excluded services are still not covered.

Chapter 5. Using the plan’s coverage for your Part D prescription drugs

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How can you get information about your drug costs

Because you are eligible for MassHealth Standard (Medicaid), you qualify for and are getting “Extra Help” from Medicare to pay for your prescription drug plan costs. Because you are in the “Extra Help” program, **some information in this *Evidence of Coverage about the costs for Part D prescription drugs may not apply to you.*** We send you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also known as the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug coverage. If you don’t have this insert, please call Customer Relations and ask for the “LIS Rider.” (Phone numbers for Customer Relations are printed on the back cover of this booklet.)

SECTION 1 Introduction

Section 1.1	This chapter describes your coverage for Part D drugs
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This chapter **explains rules for using your coverage for Part D drugs.** In addition to your coverage for Part D drugs, Tufts Health Plan Senior Care Options also covers some drugs under the plan’s medical benefits:

- The plan covers drugs you are given during covered stays in the hospital or in a skilled nursing facility. Chapter 4 (*Benefits Chart, what is covered*) tells about the benefits for drugs during a covered hospital or skilled nursing facility stay.
- Medicare Part B also provides benefits for some drugs. Part B drugs include certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility. Chapter 4 (*Benefits Chart, what is covered*) tells about your benefits for Part B drugs.

In addition to the plan’s Part D and medical benefits coverage, your drugs may be covered by Original Medicare if you are in Medicare hospice. For more information, please see Section 9.3 (*What if you’re in Medicare-certified hospice*).

In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your MassHealth Standard (Medicaid) benefits. The *Over-the-Counter (OTC) Drug List* tells you how to find out about your MassHealth Standard (Medicaid) drug coverage (see your formulary).

Section 1.2	Basic rules for the plan’s Part D drug coverage
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The plan will generally cover your drugs as long as you follow these basic rules:

- You must have a provider (a doctor or other prescriber) write your prescription.

- Effective June 1, 2015, your prescriber must either accept Medicare or file documentation with CMS showing that he or she is qualified to write prescriptions. You should ask your prescribers the next time you call or visit if they meet this condition.
- You generally must use a network pharmacy to fill your prescription. (See Section 2, *Fill your prescriptions at a network pharmacy or through the plan's mail-order service.*)
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Drug List" for short). (See Section 3, *Your drugs need to be on the plan's "Drug List."*)
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

SECTION 2 Fill your prescription at a network pharmacy or through the plan's mail-order service

Section 2.1 To have your prescription covered, use a network pharmacy

In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies. (See Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term "covered drugs" means all of the Part D prescription drugs that are covered on the plan's Drug List.

Section 2.2 Finding network pharmacies
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How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Provider Directory*, visit our website (<http://www.thpmp.org/sco>), or call Customer Relations (phone numbers are printed on the back cover of this booklet). Choose whatever is easiest for you.

You may go to any of our network pharmacies. If you switch from one network pharmacy to another, and you need a refill of a drug you have been taking, you can ask either to have a new prescription written by a provider or to have your prescription transferred to your new network pharmacy.

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can get

help from Customer Relations (phone numbers are printed on the back cover of this booklet) or use the *Provider Directory*.

What if you need a specialized pharmacy?

Sometimes prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy. Our plan will cover home infusion therapy if:
 - Your prescription drug is on our Plan's formulary or a formulary exception has been granted for your prescription,
 - Your prescription drug is not otherwise covered under our Plan's medical benefit,
 - Our plan has approved your prescription for home infusion therapy, and
 - Your prescription is written by an authorized prescriber.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. Residents may get prescription drugs through the facility's pharmacy as long as it is part of our network. If your long-term care pharmacy is not in our network, please contact Customer Relations.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Provider Directory* or call Customer Relations (phone numbers are printed on the back cover of this booklet).

Section 2.3	Using the plan's mail-order services
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For certain kinds of drugs, you can use the plan's network mail-order services. Generally, the drugs provided through mail order are drugs that you take on a regular basis, for a chronic or long-term medical condition.

Our plan's mail-order service requires you to order **at least a 30-day supply of the drug and no more than a 90-day supply**.

To get information about filling your prescriptions by mail call Customer Relations (phone numbers are listed on the back cover of this booklet).

Usually a mail-order pharmacy order will get to you in no more than 14 days. However, sometimes your mail-order may be delayed. If your order is delayed, please call Customer Relations during business hours and we will allow you to fill a partial supply of the medication at a network retail pharmacy.

New prescriptions the pharmacy receives directly from your doctor's office.

After the pharmacy receives a prescription from a health care provider, it will contact you to see if you want the medication filled immediately or at a later time. This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if needed, allow you to stop or delay the order before you are billed and it is shipped. It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

Refills on mail order prescriptions. For refills, please contact your pharmacy 25 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you. **Please call CVS Caremark Customer Care toll-free at 1-855-220-5724 (TTY 1-866-236-1069) to provide your preferred phone number. Hours of operation are 7 days a week, 7am to 12am EDT.**

Section 2.4	How can you get a long-term supply of drugs?
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The plan offers two ways to get a long-term supply of “maintenance” drugs on our plan’s Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

1. **Some retail pharmacies** in our network allow you to get a long-term supply of maintenance drugs. Your *Provider Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Customer Relations for more information (phone numbers are printed on the back cover of this booklet).
2. For certain kinds of drugs, you can use the plan’s network **mail-order services**. Our plan’s mail-order service requires you to order *at least* a 30-day supply of the drug and *no more than* a 90-day supply. See Section 2.3 for more information about using our mail-order services.

Section 2.5	When can you use a pharmacy that is not in the plan's network?
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Your prescription may be covered in certain situations

We have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- **Medical Emergencies**
 - We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care. In this situation, you will generally have to pay the full cost when you fill the prescription. You can ask us to reimburse you for our share of the cost by submitting a paper claim form.

- **When you travel or are away from the plan's service area**
 - If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. You may be able to order your prescription drugs ahead of time through our network mail order pharmacy service or through a retail network pharmacy.
 - If you are traveling within the U.S., but outside of the Plan's service area and you become ill or if you lose or run out of your prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy if you follow all other coverage rules identified within this document and a network pharmacy is not available. In this situation, you generally will have to pay the full cost when you fill the prescription. You can ask us to reimburse you for our share of the cost by submitting a paper claim form.
 - Prior to filling your prescriptions at an out-of-network pharmacy, call Customer Relations to find out if there is a network pharmacy in the area where you are traveling. Our pharmacy network is nationwide. If there are no network pharmacies in that area, Customer Relations may be able to make arrangements for you to get your prescriptions from an out-of-network pharmacy.

- **Other times you can get your prescription covered if you go to an out-of-network pharmacy**
 - We will cover your prescription at an out-of-network pharmacy if at least one of the following applies:

- If you are unable to get a covered drug in a timely manner within our service area because there are no network pharmacies within a reasonable driving distance that provide 24-hour service.
- If you are trying to fill a covered prescription drug that is not regularly stocked at an eligible network retail or mail order pharmacy (these drugs include orphan drugs or other specialty pharmaceuticals).
- Before you fill your prescription in either of these situations, call Customer Relations to see if there is a network pharmacy in your area where you can fill your prescription. If you do go to an out-of-network pharmacy for the reasons listed above, you generally will have to pay the full cost when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a claim form.

In these situations, **please check first with Customer Relations** to see if there is a network pharmacy nearby. (Phone numbers for Customer Relations are printed on the back cover of this booklet.)

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost at the time you fill your prescription. You can ask us to reimburse you. (Chapter 6, Section 2.1 explains how to ask the plan to pay you back.)

SECTION 3 Your drugs need to be on the plan's "Drug List"

Section 3.1 The "Drug List" tells which Part D drugs are covered

The plan has a "*List of Covered Drugs (Formulary)*." In this *Evidence of Coverage*, we call it the "**Drug List**" for short.

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the plan's Drug List.

The Drug List includes the drugs covered under Medicare Part D (earlier in this chapter, Section 1.1 explains about Part D drugs). In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your MassHealth Standard (Medicaid) benefits. The Over-the-Counter (OTC) drug list tells you how to find out about your MassHealth Standard (Medicaid) drug coverage (see your formulary).

We will generally cover a drug on the plan's Drug List as long as you follow the other coverage rules explained in this chapter and the use of the drug is a medically accepted indication. A "medically accepted indication" is a use of the drug that is *either*:

- Approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- -- *or* -- supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor.)

The Drug List includes both brand name and generic drugs

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Generally, it works just as well as the brand name drug and usually costs less. There are generic drug substitutes available for many brand name drugs.

What is *not* on the Drug List?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more information about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on our Drug List.
- The Over-the-Counter (OTC) Drug List tells you how to find out about your MassHealth Standard (Medicaid) drug coverage (see your formulary).

Section 3.2 How can you find out if a specific drug is on the Drug List?

You have 3 ways to find out:

1. Check the most recent Drug List we sent you in the mail.
2. Visit the plan's website (<http://www.thmp.org/sco>). The Drug List on the website is always the most current.
3. Call Customer Relations to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list. (Phone numbers for Customer Relations are printed on the back cover of this booklet.)

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. Whenever a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option. We also need to comply with Medicare's rules and regulations for drug coverage and cost-sharing.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 8, Section 7.2 for information about asking for exceptions.)

Please note that sometimes a drug may appear more than once in our drug list. This is because different restrictions or cost-sharing may apply based on factors such as the strength, amount, or form of the drug prescribed by your health care provider (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

Section 4.2 What kinds of restrictions?

Our plan uses different types of restrictions to help our members use drugs in the most effective ways. The sections below tell you more about the types of restrictions we use for certain drugs.

Restricting brand name drugs when a generic version is available

Generally, a "generic" drug works the same as a brand name drug and usually costs less. **When a generic version of a brand name drug is available, our network pharmacies will provide you the generic version.** We usually will not cover the brand name drug when a generic version is available. However, if your provider has told us the medical reason that the generic drug will not work for you, then we will cover the brand name drug. (Your share of the cost may be greater for the brand name drug than for the generic drug.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called "**prior authorization.**" Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

This requirement encourages you to try less costly but just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called "**step therapy.**"

Quantity limits

For certain drugs, we limit the amount of the drug that you can have. For example, the plan might limit how many refills you can get, or how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

Section 4.3 Do any of these restrictions apply to your drugs?

The plan's Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Customer Relations (phone numbers are printed on the back cover of this booklet) or check our website (<http://www.thmp.org/sco>).

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If there is a restriction on the drug you want to take, you should contact Customer Relations to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 8, Section 7.2 for information about asking for exceptions.)

SECTION 5 What if one of your drugs is not covered in the way you'd like it to be covered?

Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered

Suppose there is a prescription drug you are currently taking, or one that you and your provider think you should be taking. We hope that your drug coverage will work well for you, but it's possible that you might have a problem. For example:

- **What if the drug you want to take is not covered by the plan?** For example, the drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.
- **What if the drug is covered, but there are extra rules or restrictions on coverage for that drug?** As explained in Section 4, some of the drugs covered by the plan have extra rules to restrict their use. For example, you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. Or there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period. In some cases, you may want us to waive the restriction for you. For example, you might want us to cover a certain drug for you without having to try other drugs first. Or you may want us to cover more of a drug (number of pills, etc.) than we normally will cover.

There are things you can do if your drug is not covered in the way that you'd like it to be covered. If your drug is not on the Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.

Section 5.2	What can you do if your drug is not on the Drug List or if the drug is restricted in some way?
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If your drug is not on the Drug List or is restricted, here are things you can do:

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply). This will give you and your provider time to change to another drug or to file a request to have the drug covered.
- You can change to another drug.
- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, the plan can offer a temporary supply of a drug to you when your drug is not on the Drug List or when it is restricted in some way. Doing this gives you time to talk with your provider about the change in coverage and figure out what to do.

To be eligible for a temporary supply, you must meet the two requirements below:

1. The change to your drug coverage must be one of the following types of changes:

- The drug you have been taking is **no longer on the plan's Drug List**.
- -- or -- the drug you have been taking is **now restricted in some way** (Section 4 in this chapter tells about restrictions).

2. You must be in one of the situations described below:

- **For those members who were in the plan last year and aren't in a long-term care (LTC) facility:**

We will cover a temporary supply of your drug **during the first 90 days of the calendar year**. This temporary supply will be for a maximum of a 30-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 30-day supply of medication. The prescription must be filled at a network pharmacy.

- **For those members who are new to the plan and aren't in a long-term care (LTC) facility:**

We will cover a temporary supply of your drug **during the first 90 days of your membership** in the plan. This temporary supply will be for a maximum of a 30 day supply. If your prescription is written for fewer days, we allow multiple fills to provide up to a maximum of a 30-day supply of medication. The prescription must be filled at a network pharmacy.

- **For those members who were in the plan last year and reside in a long-term care (LTC) facility:**

We will cover a temporary supply of your drug **during the first 90 days of the calendar year** in the plan. The total supply will be for a maximum of a 91-98 day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 91-98 day supply of medication. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

- **For those members who are new to the plan and reside in a long-term care (LTC) facility:**

We will cover a temporary supply of your drug **during the first 90 days of your membership** in the plan. The total supply will be for a maximum of a 91-98 day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 91-98 day supply of medication. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

- **For those members who have been in the plan for more than 90 days and reside in a long-term care (LTC) facility and need a supply right away:**

We will cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the above long-term care transition supply.

- As a current member, if you are in a long term facility and if you experience an unplanned drug change due to a change in level of care, you can request that we approve a one-time, temporary fill of the non-covered medication to allow you time to discuss a transition plan with your physician. Your physician can also request an exception to coverage for the non-covered drug based on review for medical necessity following the standard exception process outlined previously. The temporary "first fill" will generally be up to a 31-day supply, but may be extended to allow you and your physician time to manage the complexities of multiple medications or when special circumstances warrant. You or your personal representative can request a temporary prescription fill by calling the Tufts Health Plan Senior Care Options Customer Relations department.

Please note that our transition policy applies only to those drugs that are “Part D drugs” and bought at a network pharmacy. The transition policy can't be used to buy a non-Part D drug or a drug out of network, unless you qualify for out of network access.

To ask for a temporary supply, call Customer Relations (phone numbers are printed on the back cover of this booklet).

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug. The sections below tell you more about these options.

You can change to another drug

Start by talking with your provider. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call Customer Relations to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you. (Phone numbers for Customer Relations are printed on the back cover of this booklet.)

You can ask for an exception

You and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule. For example, you can ask the plan to cover a drug even though it is not on the plan's Drug List. Or you can ask the plan to make an exception and cover the drug without restrictions.

If you and your provider want to ask for an exception, Chapter 8, Section 7.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

SECTION 6 What if your coverage changes for one of your drugs?

Section 6.1 The Drug List can change during the year
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Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the plan might make many kinds of changes to the Drug List. For example, the plan might:

- **Add or remove drugs from the Drug List.** New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.

- **Add or remove a restriction on coverage for a drug** (for more information about restrictions to coverage, see Section 4 in this chapter).
- **Replace a brand name drug with a generic drug.**

In almost all cases, we must get approval from Medicare for changes we make to the plan's Drug List.

Section 6.2 What happens if coverage changes for a drug you are taking?

How will you find out if your drug's coverage has been changed?

If there is a change to coverage *for a drug you are taking*, the plan will send you a notice to tell you. Normally, **we will let you know at least 60 days ahead of time.**

Once in a while, a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons. If this happens, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away. Your provider will also know about this change, and can work with you to find another drug for your condition.

Do changes to your drug coverage affect you right away?

If any of the following types of changes affect a drug you are taking, the change will not affect you until January 1 of the next year if you stay in the plan:

- If we put a new restriction on your use of the drug.
- If we remove your drug from the Drug List, but not because of a sudden recall or because a new generic drug has replaced it.

If any of these changes happens for a drug you are taking, then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restriction to your use of the drug. However, on January 1 of the next year, the changes will affect you.

In some cases, you will be affected by the coverage change before January 1:

- If a **brand name drug you are taking is replaced by a new generic drug**, the plan must give you at least 60 days' notice or give you a 60-day refill of your brand name drug at a network pharmacy.
 - During this 60-day period, you should be working with your provider to switch to the generic or to a different drug that we cover.
 - Or you and your provider can ask the plan to make an exception and continue to cover the brand name drug for you. For information on how to ask for an

exception, see Chapter 8 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

- Again, if a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away.
 - Your provider will also know about this change, and can work with you to find another drug for your condition.

SECTION 7 What types of drugs are *not* covered by the plan?

Section 7.1 Types of drugs we do not cover
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This section tells you what kinds of prescription drugs are “excluded.” This means neither Medicare nor MassHealth Standard (Medicaid) pays for these drugs.

We won't pay for the drugs that are listed in this section. The only exception: If the requested drug is found upon appeal to be a drug that is not excluded under Part D and we should have paid for or covered it because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to Chapter 8, Section 7.5 in this booklet.) If the drug excluded by our plan is also excluded by MassHealth Standard (Medicaid), you must pay for it yourself.

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- Our plan usually cannot cover off-label use. “Off-label use” is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
 - Generally, coverage for “off-label use” is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor. If the use is not supported by any of these reference books, then our plan cannot cover its “off-label use.”

Also, by law, the categories of drugs listed below are not covered by Medicare. However, some of these drugs may be covered for you under your MassHealth Standard (Medicaid) drug coverage, as indicated below.

- Non-prescription drugs (also called over-the-counter drugs). Certain over-the-counter drugs are covered for you under your MassHealth Standard (Medicaid) drug coverage.

- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations. Certain vitamins and mineral products are covered for you under your MassHealth Standard (Medicaid) drug coverage.
- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra, and Caverject
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

SECTION 8 Show your plan membership card when you fill a prescription

Section 8.1 Show your membership card

To fill your prescription, show your plan membership card at the network pharmacy you choose. When you show your plan membership card, the network pharmacy will automatically bill the plan for your covered prescription drug.

Section 8.2 What if you don't have your membership card with you?

If you don't have your plan membership card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information.

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up.** (You can then **ask us to reimburse you.** See Chapter 6, Section 2.1 for information about how to ask the plan for reimbursement.)

SECTION 9 Part D drug coverage in special situations

Section 9.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?
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If you are admitted to a hospital or to a skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, the plan will cover your drugs as long as the drugs meet all of

our rules for coverage. See the previous parts of this section that tell about the rules for getting drug coverage.

Section 9.2 What if you're a resident in a long-term care (LTC) facility?

Usually, a long-term care (LTC) facility (such as a nursing home) has its own pharmacy, or a pharmacy that supplies drugs for all of its residents. If you are a resident of a long-term care facility, you may get your prescription drugs through the facility's pharmacy as long as it is part of our network.

Check your *Provider Directory* to find out if your long-term care facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Customer Relations (phone numbers are printed on the back cover of this booklet).

What if you're a resident in a long-term care (LTC) facility and become a new member of the plan?

If you need a drug that is not on our Drug List or is restricted in some way, the plan will cover a **temporary supply** of your drug during the first 90 days of your membership. The total supply will be for a maximum of a 91-98 day supply, or less if your prescription is written for fewer days. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.) If you have been a member of the plan for more than 90 days and need a drug that is not on our Drug List or if the plan has any restriction on the drug's coverage, we will cover one 31-day supply, or less if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If you and your provider want to ask for an exception, Chapter 8, Section 7.4 tells what to do.

Section 9.3 What if you're in Medicare-certified hospice?

Drugs are never covered by both hospice and our plan at the same time. If you are enrolled in Medicare hospice and require an anti-nausea, laxative, pain medication or antianxiety drug that is not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

In the event you either revoke your hospice election or are discharged from hospice our plan should cover all your drugs. To prevent any delays at a pharmacy when your Medicare hospice

benefit ends, you should bring documentation to the pharmacy to verify your revocation or discharge. See the previous parts of this section that tell about the rules for getting drug coverage under Part D.

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one provider who prescribes their drugs.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

- Possible medication errors
- Drugs that may not be necessary because you are taking another drug to treat the same medical condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions written for drugs that have ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you are taking.

If we see a possible problem in your use of medications, we will work with your provider to correct the problem.

Section 10.2 Medication Therapy Management (MTM) and other programs to help members manage their medications

We have programs that can help our members with special situations. For example, some members have several complex medical conditions or they may need to take many drugs at the same time, or they could have very high drug costs.

These programs are voluntary and free to members. A team of pharmacists and doctors developed the programs for us. The programs can help make sure that our members are using the drugs that work best to treat their medical conditions and help us identify possible medication errors. One program is called a Medication Therapy Management (MTM) program. Some members who take several medications for different medical conditions may qualify. A pharmacist or other health professional will give you a comprehensive review of all your medications. You can talk about how best to take your medications, your costs, or any problems you're having. You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications, with

space for you to take notes or write down any follow-up questions. You'll also get a personal medication list that will include all the medications you're taking and why you take them.

It's a good idea to schedule your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, take your medication list with you if you go to the hospital or emergency room.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you from the program. If you have any questions about these programs, please contact Customer Relations (phone numbers are printed on the back cover of this booklet).

SECTION 11 We send you reports that explain payments for your drugs and which payment stage you are in

Section 11.1 We send you a monthly report called the "Explanation of Benefits" (the "EOB")

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your "**out-of-pocket**" cost.
- We keep track of your "**total drug costs.**" This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.

Our plan will prepare a written report called the *Explanation of Benefits* (it is sometimes called the "EOB") when you have had one or more prescriptions filled through the plan during the previous month. It includes:

- **Information for that month.** This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called "year-to-date" information. It shows you the total drug costs and total payments for your drugs since the year began.

Section 11.2 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay for the drug. For instructions on how to do this, go to Chapter 6, Section 2 of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
 - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.
 - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
 - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. You should keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive an *Explanation of Benefits* (an EOB) in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call us at Customer Relations (phone numbers are printed on the back cover of this booklet). Be sure to keep these reports. They are an important record of your drug expenses.

Section 11.3 How can you get information about your drug costs if you're receiving "Extra Help" with your Part D prescription drug costs?

Because you are eligible for Medicaid, you qualify for and are getting "Extra Help" from Medicare to pay for your prescription drug plan costs. Because you are in the "Extra Help" program, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** We send you a separate insert, called the "Evidence

of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also known as the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug coverage. If you don’t have this insert, please call Customer Relations and ask for the “LIS Rider.” (Phone numbers for Customer Relations are printed on the back cover of this booklet.)

Chapter 6. Asking us to pay a bill you have received for covered medical services or drugs

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SECTION 1 Situations in which you should ask us to pay for your covered services or drugs

Section 1.1 If you pay for your covered services or drugs, or if you receive a bill, you can ask us for payment
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Our network providers bill the plan directly for your covered services and drugs – you should not receive a bill for covered services or drugs. If you get a bill for medical care or drugs you have received, you should send this bill to us so that we can pay it. When you send us the bill, we will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

If you have already paid for services or drugs covered by the plan, you can ask our plan to pay you back (paying you back is often called “reimbursing” you). It is your right to be paid back by our plan whenever you’ve paid for medical services or drugs that are covered by our plan. When you send us a bill you have already paid, we will look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we will pay you back for the services or drugs.

Here are examples of situations in which you may need to ask our plan to pay you back or to pay a bill you have received.

1. When you’ve received emergency or urgently needed medical care from a provider who is not in our plan’s network

You can receive emergency services from any provider, whether or not the provider is a part of our network. When you receive emergency or urgently needed care from a provider who is not part of our network, you should ask the provider to bill the plan.

- If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back. Send us the bill, along with documentation of any payments you have made.
- At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
 - If the provider is owed anything, we will pay the provider directly.
 - If you have already paid for the service, we will pay you back.

2. When a network provider sends you a bill you think you should not pay

Network providers should always bill the plan directly. But sometimes they make mistakes, and ask you to pay for your services.

- You only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called “balance

billing.” This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don’t pay certain provider charges.

- Whenever you get a bill from a network provider, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, send us the bill along with documentation of any payment you have made. You should ask us to pay you back for your covered services.

3. If you are retroactively enrolled in our plan.

Sometimes a person’s enrollment in the plan is retroactive. (Retroactive means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered services or drugs after your enrollment date, you can ask us to pay you back. You will need to submit paperwork for us to handle the reimbursement.

- Please contact Customer Relations for additional information about how to ask us to pay you back and deadlines for making your request. (Phone numbers for Customer Relations are printed on the back cover of this booklet.)

4. When you use an out-of-network pharmacy to get a prescription filled

If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. (We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to Chapter 5, Section 2.5 to learn more.)

- Save your receipt and send a copy to us when you ask us to pay you back.

5. When you pay the full cost for a prescription because you don’t have your plan membership card with you

If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

- Save your receipt and send a copy to us when you ask us to pay you back.

6. When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on the plan's *List of Covered Drugs (Formulary)*; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for the drug.

When you send us a request for payment, we will review your request and decide whether the service or drug should be covered. This is called making a "coverage decision." If we decide it should be covered, we will pay for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 8 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has information about how to make an appeal.

SECTION 2 How to ask us to pay you back or to pay a bill you have received

Section 2.1 How and where to send us your request for payment

Send us your request for payment, along with your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website (<http://www.thpmp.org/sco>) or call Customer Relations and ask for the form. (Phone numbers for Customer Relations are printed on the back cover of this booklet.)

Mail your request for payment together with any bills or receipts for medical services to us at this address:

Tufts Health Plan Senior Care Options
Claims Department
P.O. Box 9183
Watertown, MA 02471-9183

Mail your request for payment together with any bills or receipts for prescription medications to us at this address:

CVS/Caremark
P.O. Box 52066
Phoenix, AZ 85072-2066

Contact Customer Relations if you have any questions (phone numbers are printed on the back cover of this booklet). If you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

SECTION 3 We will consider your request for payment and say yes or no

Section 3.1 We check to see whether we should cover the service or drug

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the medical care or drug is covered and you followed all the rules for getting the care or drug, we will pay for the service. If you have already paid for the service or drug, we will mail your reimbursement to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services covered. Chapter 5 explains the rules you need to follow for getting your Part D prescription drugs covered.)
- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we will not pay for the care or drug. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

Section 3.2 If we tell you that we will not pay for the medical care or drug, you can make an appeal
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If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details on how to make this appeal, go to Chapter 8 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*). The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 5 of Chapter 8. Section 5 is an introductory section that explains the process for coverage decisions and appeals and gives

definitions of terms such as “appeal.” Then after you have read Section 5, you can go to the section in Chapter 8 that tells what to do for your situation:

- If you want to make an appeal about getting paid back for a medical service, go to Section 6.3 in Chapter 8.
- If you want to make an appeal about getting paid back for a drug, go to Section 7.5 of Chapter 8.

SECTION 4 Other situations in which you should save your receipts and send copies to us

Section 4.1	In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs
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There are some situations when you should let us know about payments you have made for your drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your out-of-pocket costs correctly. This may help you to qualify for the Catastrophic Coverage Stage more quickly.

Below is an example of a situation when you should send us copies of receipts to let us know about payments you have made for your drugs:

When you get a drug through a patient assistance program offered by a drug manufacturer

Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside the plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.

- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** Because you are getting your drug through the patient assistance program and not through the plan’s benefits, we will not pay for these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

Since you are not asking for payment in the case described above, this situation is not considered a coverage decision. Therefore, you cannot make an appeal if you disagree with our decision.

Chapter 7. Your rights and responsibilities

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SECTION 1 Our plan must honor your rights as a member of the plan

Section 1.1 We must provide information in a way that works for you (in languages other than English)

To get information from us in a way that works for you, please call Customer Relations (phone numbers are printed on the back cover of this booklet).

Our plan has people and free language interpreter services available to answer questions from non-English speaking members. We can also provide certain written materials in Spanish and large print if you need it. If you are eligible for Medicare because of a disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you.

If you have any trouble getting information from our plan because of problems related to language or a disability, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and tell them that you want to file a complaint. TTY users call 1-877-486-2048.

Sección 1.1 Debemos proporcionar información en una manera que sea adecuada para usted (en idiomas distintos al inglés)

Para obtener información de una manera que sea adecuada para usted, llame a atención al cliente (los números de teléfono están en la contraportada de este folleto).

Nuestro plan tiene personal y servicios gratuitos de interpretación disponibles para responder a las preguntas de los miembros que no hablan inglés. También, si lo necesita, podemos proporcionarle información en idiomas distintos al inglés. Si es elegible para Medicare debido a una discapacidad, estamos obligados a proporcionarle información sobre los beneficios del plan en una forma que sea accesible y apropiada para usted.

Si tiene problemas para obtener información de nuestro plan por problemas relacionados con el idioma o una discapacidad, llame a Medicare al 1-800-MEDICARE (1-800-633-4227), 24 horas al día, 7 días a la semana, y dígales que desea presentar una queja. Los usuarios de TTY deben llamar al 1-877-486-2048.

Section 1.2 We must treat you with fairness, dignity, and respect at all times
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Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, ethnicity, national origin, religion, gender, age, mental or

physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Customer Relations (phone numbers are printed on the back cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Customer Relations can help.

Section 1.3	We must ensure that you get timely access to your covered services and drugs
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As a member of our plan, you have the right to choose a Primary Care Physician (PCP) in the plan's network to provide and arrange for your covered services (Chapter 3 explains more about this). Call Customer Relations to learn which doctors are accepting new patients (phone numbers are printed on the back cover of this booklet). You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

As a plan member, you have the right to get appointments and covered services from the plan's network of providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 8, Section 11 of this booklet tells what you can do. (If we have denied coverage for your medical care or drugs and you don't agree with our decision, Chapter 8, Section 5 tells what you can do.)

Section 1.4	We must protect the privacy of your personal health information
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Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practice," that tells about these rights and explains how we protect the privacy of your health information.

- Our Notice of Privacy Practices was updated in August 2013. You can view a copy of the Notice on our website or, if you would like a copy sent to you, call Customer Relations (phone numbers are on the cover of this booklet).

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you first.* Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
 - For example, we are required to release health information to government agencies that are checking on quality of care.
 - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Customer Relations (phone numbers are printed on the back cover of this booklet).

Section 1.5	We must give you information about the plan, its network of providers, and your covered services
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As a member of Tufts Health Plan Senior Care Options, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English. (Certain materials are available in Spanish or large print.)

If you want any of the following kinds of information, please call Customer Relations (phone numbers are printed on the back cover of this booklet):

- **Information about our plan.** This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **Information about our network providers including our network pharmacies.**
 - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
 - For a list of the providers and pharmacies in the plan's network, see the Provider Directory.
 - For more detailed information about our providers or pharmacies, you can call Customer Relations (phone numbers are printed on the back cover of this booklet) or visit our website at <http://www.thmp.org/sco>.
- **Information about your coverage and the rules you must follow when using your coverage.**
 - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
 - To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 of this booklet plus the plan's *List of Covered Drugs (Formulary)*. These chapters, together with the *List of Covered Drugs (Formulary)*, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
 - If you have questions about the rules or restrictions, please call Customer Relations (phone numbers are printed on the back cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
 - If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.
 - If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 8 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 8 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
 - If you want to ask our plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 7 of this booklet.

Section 1.6 We must support your right to make decisions about your care

You have the right to know your treatment options and participate in decisions about your health care

You have the right to get full information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices *in a way that you can understand*.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say “no.”** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 8 of this booklet tells how to ask the plan for a coverage decision.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called “**advance directives**.” There are different types of advance directives and different names

for them. Documents called “**living will**” and “**power of attorney for health care**” are examples of advance directives.

If you want to use an “advance directive” to give your instructions, here is what to do:

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can’t. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital.**

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with: The Department of Public Health, Commissioner’s Office, 250 Washington Street, Boston, MA 02110, 1-617-753-8000.

Section 1.7	You have the right to make complaints and to ask us to reconsider decisions we have made
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If you have any problems or concerns about your covered services or care, Chapter 8 of this booklet tells you what you can do. It gives the details about how to deal with all types of problems and complaints.

As explained in Chapter 8, what you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Customer Relations (phone numbers are printed on the back cover of this booklet).

Section 1.8	What can you do if you believe you are being treated unfairly or your rights are not being respected?
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If it is about discrimination, call the Office for Civil Rights

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, *and it's not* about discrimination, you can get help dealing with the problem you are having:

- You can **call Customer Relations** (phone numbers are printed on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 1.9	How to get more information about your rights and responsibilities
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There are several places where you can get more information about your rights:

- You can **call Customer Relations** (phone numbers are printed on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare**.
 - You can visit the Medicare website to read or download the publication "Your Medicare Rights & Protections." (The publication is available at: <http://www.medicare.gov/Pubs/pdf/11534.pdf>)
 - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 2 You have some responsibilities as a member of the plan

Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Relations (phone numbers are printed on the back cover of this booklet). We're here to help.

- ***Get familiar with your covered services and the rules you must follow to get these covered services.*** Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered services.
 - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
 - Chapter 5 gives the details about your coverage for Part D prescription drugs.
- ***If you have any information that Tufts Health Plan Senior Care Options may need including other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.*** Please call Customer Relations to let us know (phone numbers are printed on the back cover of this booklet).
 - We are required to follow rules set by Medicare and MassHealth Standard (Medicaid) to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called “**coordination of benefits**” because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 7.)
- ***Tell your doctor and other health care providers that you are enrolled in our plan.*** Show your plan membership card whenever you get your medical care or Part D prescription drugs.
- ***Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.***
 - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
 - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.

- If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- ***Be considerate.*** *We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.*
- ***Pay what you owe.*** *As a plan member, you are responsible for these payments:*
 - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. For most Tufts Health Plan Senior Care Options members, MassHealth Standard (Medicaid) pays for your Part A premium (if you don't qualify for it automatically) and for your Part B premium. If MassHealth Standard (Medicaid) is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain a member of the plan.
 - If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
 - If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see Chapter 8 of this booklet for information about how to make an appeal.
 - If you are required to pay the extra amount for Part D because of your higher income (as reported on your last tax return), you must pay the extra amount directly to the government to remain a member of the plan.
- ***Tell us if you move.*** *If you are going to move, it's important to tell us right away. Call Customer Relations (phone numbers are printed on the back cover of this booklet).*
 - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area.
 - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
 - If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.
- Call Customer Relations for help if you have questions or concerns. **We also welcome any suggestions you may have for improving our plan.**
 - Phone numbers and calling hours for Customer Relations are printed on the back cover of this booklet.
 - For more information on how to reach us, including our mailing address, please see Chapter 2.

SECTION 3 How We Help You Receive Quality Care

Section 3.1 Medical Management Program
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Our Medical Management (MM) Program helps arrange for members to receive quality healthcare in an appropriate treatment setting. MM refers to the process by which Tufts Health Plan or a health care provider authorizes coverage for health care procedures or treatments. Coverage decisions are based on medical necessity guidelines utilizing Medicare and MassHealth Standard (Medicaid) coverage guidelines and appropriateness of care, service, and setting.

You have the right to a candid discussion of appropriate or medically necessary treatment options, regardless of cost or benefit coverage.

Tufts Health Plan's Medical Management Program follows all Medicare and MassHealth Standard (Medicaid) Coverage Guidelines.

**Chapter 8. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

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BACKGROUND

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

This chapter explains the processes for handling problems and concerns. The process you use to handle your problem depends on two things:

1. Whether your problem is about benefits covered by **Medicare** or **MassHealth Standard (Medicaid)**. If you would like help deciding whether to use the Medicare process or the MassHealth Standard (Medicaid) process, or both, please contact Customer Relations (phone numbers are printed on the back cover of this booklet).
2. The type of problem you are having:
 - For some types of problems, you need to use the **process for coverage decisions and appeals**.
 - For other types of problems, you need to use the **process for making complaints**.

These processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Which one do you use? The guide in Section 3 will help you identify the right process to use.

Section 1.2 What about the legal terms?

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says “making a complaint” rather than “filing a grievance,” “coverage decision” rather than “organization determination” or “coverage determination,” and “Independent Review Organization” instead of “Independent Review Entity.” It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 You can get help from government organizations that are not connected with us

Section 2.1 Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers in Chapter 2, Section 3 of this booklet.

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can visit the Medicare website (<http://www.medicare.gov>).

You can get help and information from MassHealth Standard (Medicaid)

<i>MassHealth (Massachusetts Medicaid program)</i>	
CALL	1-800-841-2900
TTY	1-800-497-4648
	This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

WRITE	MassHealth Customer Service Center 55 Summer Street Boston, MA 02110
WEB SITE	http://www.mass.gov

The Massachusetts Community Care Ombudsman Program helps people enrolled in MassHealth Standard (Medicaid) with service or billing problems. They can help you file a grievance or appeal with our plan.

Massachusetts Community Care Ombudsman Program	
CALL	1-617-727-7750 or 1-800-AGE-INFO (1-800-243-4636)
TTY	1-800-872-0166 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Executive Office of Elder Affairs One Ashburton Place, 5 th Floor Boston, MA 02108
WEB SITE	http://www.mass.gov

SECTION 3 To deal with your problem, which process should you use?

Section 3.1 Should you use the process for Medicare benefits or MassHealth Standard (Medicaid) benefits?
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Because you have Medicare and get assistance from MassHealth Standard (Medicaid), you have different processes that you can use to handle your problem or complaint. Which process you use depends on whether the problem is about Medicare benefits or MassHealth Standard (Medicaid) benefits. If your problem is about a benefit covered by Medicare, then you should use the Medicare process. If your problem is about a benefit covered by MassHealth Standard (Medicaid), then you should use the MassHealth Standard (Medicaid) process. If you would like help deciding whether to use the Medicare process or the MassHealth Standard (Medicaid) process, please contact Customer Relations (phone numbers are printed on the back cover of this booklet).

The Medicare process and MassHealth Standard (Medicaid) process are described in different parts of this chapter. To find out which part you should read, use the chart below.

To figure out which part of this chapter will help with your specific problem or concern,
START HERE

Is your problem about Medicare benefits or MassHealth Standard (Medicaid) benefits?

(If you would like help deciding whether your problem is about Medicare benefits or MassHealth Standard (Medicaid) benefits, please contact Customer Relations. Phone numbers for Customer Relations are printed on the back cover of this booklet.)

My problem is about **Medicare** benefits.

Go to the next section of this chapter, **Section 4, “Handling problems about Medicare your benefits.”**

My problem is about **MassHealth Standard (Medicaid)** coverage.

Skip ahead to **Section 12** of this chapter, **“Handling problems about your MassHealth Standard (Medicaid) benefits.”**

PROBLEMS ABOUT YOUR MEDICARE BENEFITS

SECTION 4 Handling problems about your Medicare benefits

Section 4.1	Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?
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If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The chart below will help you find the right section of this chapter for problems or complaints about **benefits covered by Medicare**.

To figure out which part of this chapter will help with your problem or concern about your **Medicare** benefits, use this chart:

Is your problem or concern about your benefits or coverage?

(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)

Yes. My problem is about benefits or coverage.

Go on to the next section of this chapter, **Section 5, “A guide to the basics of coverage decisions and appeals.”**

No. My problem is not about benefits or coverage.

Skip ahead to **Section 11** at the end of this chapter: **“How to make a complaint about quality of care, waiting times, customer service or other concerns.”**

SECTION 5 A guide to the basics of coverage decisions and appeals

Section 5.1 Asking for coverage decisions and making appeals: the big picture

The process for asking for coverage decisions and appeals deals with problems related to your benefits and coverage, including problems related to payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. We are making a coverage decision whenever we decide what is covered for you and how much we pay. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

In some cases we might decide a service or drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision and you are not satisfied with this decision, you can “appeal” the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you make an appeal, we review the coverage decision we have made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review we give you our decision.

If we say no to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to us. (In some situations, your case will be automatically sent to the independent organization for a Level 2 Appeal. If this happens, we will let you know. In other situations, you will need to ask for a Level 2 Appeal.) If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of appeal.

Section 5.2	How to get help when you are asking for a coverage decision or making an appeal
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Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- **You can call us at Customer Relations** (phone numbers are printed on the back cover of this booklet).
- **To get free help from an independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter).
- **Your doctor can make a request for you.**
 - For medical care, your doctor can request a coverage decision or a Level 1 Appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2. To request any appeal after Level 2, your doctor must be appointed as your representative.
 - For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 or Level 2 Appeal on your behalf. To request any appeal after Level 2, your doctor or other prescriber must be appointed as your representative.

- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your “representative” to ask for a coverage decision or make an appeal.
 - There may be someone who is already legally authorized to act as your representative under State law.
 - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Customer Relations (phone numbers are printed on the back cover of this booklet) and ask for the “Appointment of Representative” form. (The form is also available on Medicare’s website at <http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf>) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 5.3	Which section of this chapter gives the details for your situation?
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There are four different types of situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 6** of this chapter: “Your medical care: How to ask for a coverage decision or make an appeal”
- **Section 7** of this chapter: “Your Part D prescription drugs: How to ask for a coverage decision or make an appeal”
- **Section 8** of this chapter: “How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon”
- **Section 9** of this chapter: “How to ask us to keep covering certain medical services if you think your coverage is ending too soon” (*Applies to these services only*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you’re not sure which section you should be using, please call Customer Relations (phone numbers are printed on the back cover of this booklet). You can also get help or information from government organizations such as your State Health Insurance Assistance Program (Chapter 2, Section 3, of this booklet has the phone numbers for this program).

SECTION 6 Your medical care: How to ask for a coverage decision or make an appeal



Have you read Section 5 of this chapter (*A guide to “the basics” of coverage decisions and appeals*)? If not, you may want to read it before you start this section.

Section 6.1	This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for your care
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This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this booklet: *Benefits Chart (what is covered)*. To keep things simple, we generally refer to “medical care coverage” or “medical care” in the rest of this section, instead of repeating “medical care or treatment or services” every time.

This section tells what you can do if you are in any of the five following situations:

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.
2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan.
3. You have received medical care or services that you believe should be covered by the plan, but we have said we will not pay for this care.
4. You have received and paid for medical care or services that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care.
5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.
 - **NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services**, you need to read a separate section of this chapter because special rules apply to these types of care. Here’s what to read in those situations:
 - Chapter 8, Section 8: *How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon.*
 - Chapter 8, Section 9: *How to ask us to keep covering certain medical services if you think your coverage is ending too soon.* This section is about three services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.

- For *all other* situations that involve being told that medical care you have been getting will be stopped, use this section (Section 6) as your guide for what to do.

Which of these situations are you in?

If you are in this situation:	This is what you can do:
Do you want to find out whether we will cover the medical care or services you want?	You can ask us to make a coverage decision for you. Go to the next section of this chapter, Section 6.2 .
Have we already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for?	You can make an appeal . (This means you are asking us to reconsider.) Skip ahead to Section 6.3 of this chapter.
Do you want to ask us to pay you back for medical care or services you have already received and paid for?	You can send us the bill. Skip ahead to Section 6.5 of this chapter.

Section 6.2 Step-by-step: How to ask for a coverage decision (how to ask our plan to authorize or provide the medical care coverage you want)

Legal Terms

When a coverage decision involves your medical care, it is called an “**organization determination.**”

Step 1: You ask our plan to make a coverage decision on the medical care you are requesting. If your health requires a quick response, you should ask us to make a “fast coverage decision.”

Legal Terms

A “fast coverage decision” is called an “**expedited determination.**”

How to request coverage for the medical care you want

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this.
- For the details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision about your medical care.*

Generally we use the standard deadlines for giving you our decision

When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. **A standard coverage decision means we will give you an answer within 14 days** after we receive your request.

- **However, we can take up to 14 more calendar days** if you ask for more time, or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing.
- If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)

If your health requires it, ask us to give you a “fast coverage decision”

- **A fast coverage decision means we will answer within 72 hours.**
 - **However, we can take up to 14 more calendar days** if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing.
 - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.) We will call you as soon as we make the decision.
- **To get a fast coverage decision, you must meet two requirements:**
 - You can get a fast coverage decision *only* if you are asking for coverage for medical care *you have not yet received*. (You cannot get a fast coverage decision if your request is about payment for medical care you have already received.)

- You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor tells us that your health requires a “fast coverage decision,” we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own, without your doctor’s support, we will decide whether your health requires that we give you a fast coverage decision.
 - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
 - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
 - The letter will also tell how you can file a “fast complaint” about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)

Step 2: We consider your request for medical care coverage and give you our answer.

Deadlines for a “fast” coverage decision

- Generally, for a fast coverage decision, we will give you our answer **within 72 hours**.
 - As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing.
 - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)
 - If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 6.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our coverage decision, we will provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a detailed written explanation as to why we said no.

Deadlines for a “standard” coverage decision

- Generally, for a standard coverage decision, we will give you our answer **within 14 days of receiving your request**.
 - We can take up to 14 more calendar days (“an extended time period”) under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing.
 - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)
 - If we do not give you our answer within 14 days (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 6.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 14 days after we received your request. If we extended the time needed to make our coverage decision, we will provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Step 3: If we say no to your request for coverage for medical care, you decide if you want to make an appeal.

- If we say no, you have the right to ask us to reconsider – and perhaps change – this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see Section 6.3 below).

Section 6.3	Step-by-step: How to make a Level 1 Appeal (How to ask for a review of a medical care coverage decision made by our plan)
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Legal Terms

An appeal to the plan about a medical care coverage decision is called a plan “ reconsideration. ”

Step 1: You contact us and make your appeal. If your health requires a quick response, you must ask for a “**fast appeal.**”

What to do

- **To start an appeal you, your doctor, or your representative, must contact us.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 and look for section called, *How to contact us when you are making an appeal about your medical care.*
- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a request.**
 - If you have someone appealing our decision for you other than your doctor, your appeal must include an Appointment of Representative form authorizing this person to represent you. (To get the form, call Customer Relations (phone numbers are printed on the back cover of this booklet) and ask for the “Appointment of Representative” form. It is also available on Medicare’s website at <http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf>) While we can accept an appeal request without the form, we cannot complete our review until we receive it. If we do not receive the form within 44 days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the Independent Review Organization to review our decision.
- **If you are asking for a fast appeal, make your appeal in writing or call us at the phone number shown in Chapter 2, Section 1** (*How to contact us when you are making an appeal about your medical care*).
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from

contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

- **You can ask for a copy of the information regarding your medical decision and add more information to support your appeal.**
 - You have the right to ask us for a copy of the information regarding your appeal.
 - If you wish, you and your doctor may give us additional information to support your appeal.

If your health requires it, ask for a “fast appeal” (you can make a request by calling us)

Legal Terms
A “fast appeal” is also called an “ expedited reconsideration. ”

- If you are appealing a decision we made about coverage for care you have not yet received, you and/or your doctor will need to decide if you need a “fast appeal.”
- The requirements and procedures for getting a “fast appeal” are the same as those for getting a “fast coverage decision.” To ask for a fast appeal, follow the instructions for asking for a fast coverage decision. (These instructions are given earlier in this section.)
- If your doctor tells us that your health requires a “fast appeal,” we will give you a fast appeal.

Step 2: We consider your appeal and we give you our answer.

- When we are reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if we need it. We may contact you or your doctor to get more information.

Deadlines for a “fast” appeal

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal.** We will give you our answer sooner if your health requires us to do so.
 - However, if you ask for more time, or if we need to gather more information that may benefit you, we **can take up to 14 more calendar days.** If we decide to take extra days to make the decision, we will tell you in writing.

- If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

Deadlines for a “standard” appeal

- If we are using the standard deadlines, we must give you our answer **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. We will give you our decision sooner if your health condition requires us to.
 - However, if you ask for more time, or if we need to gather more information that may benefit you, **we can take up to 14 more calendar days**.
 - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)
 - If we do not give you an answer by the deadline above (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 30 days after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

Step 3: If our plan says no to part or all of your appeal, your case will automatically be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your appeal, **we are required to send your appeal to the “Independent Review Organization.”** When

we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

Section 6.4 Step-by-step: How a Level 2 Appeal is done

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews our decision for your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms

The formal name for the “Independent Review Organization” is the “**Independent Review Entity.**” It is sometimes called the “**IRE.**”

Step 1: The Independent Review Organization reviews your appeal.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- We will send the information about your appeal to this organization. This information is called your “case file.” **You have the right to ask us for a copy of your case file.**
- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

If you had a “fast” appeal at Level 1, you will also have a “fast” appeal at Level 2

- If you had a fast appeal to our plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 72 hours** of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days.**

If you had a “standard” appeal at Level 1, you will also have a “standard” appeal at Level 2

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**.

Step 2: The Independent Review Organization gives you their answer.

The Independent Review Organization will tell you its decision in writing and explain the reasons for it.

- **If the review organization says yes to part or all of what you requested**, we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization.
- **If this organization says no to part or all of your appeal**, it means they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called “upholding the decision.” It is also called “turning down your appeal.”)
 - There is a certain dollar value that must be in dispute to continue with the appeals process. For example, to continue and make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final. The written notice you get from the Independent Review Organization will tell you how to find out the dollar amount to continue the appeals process.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you got after your Level 2 Appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 6.5	What if you are asking us to pay you back for a bill you have received for medical care?
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If you want to ask us for payment for medical care, start by reading Chapter 6 of this booklet: *Asking us to pay a bill you have received for covered medical services or drugs*. Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 5.1 of this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service (see Chapter 4: *Benefits Chart (what is covered)*). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: *Using the plan's coverage for your medical services*).

We will say yes or no to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for your medical care within 60 calendar days after we receive your request. Or, if you haven't paid for the services, we will send the payment directly to the provider. When we send the payment, it's the same as saying *yes* to your request for a coverage decision.)
- If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why in detail. (When we turn down your request for payment, it's the same as saying *no* to your request for a coverage decision.)

What if you ask for payment and we say that we will not pay?

If you do not agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in part 5.3 of this section. Go to this part for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)

- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

SECTION 7 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal



Have you read Section 5 of this chapter (A guide to “the basics” of coverage decisions and appeals)? If not, you may want to read it before you start this section.

Section 7.1	This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug
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Your benefits as a member of our plan include coverage for many prescription drugs. Please refer to our plan’s *List of Covered Drugs (Formulary)*. To be covered, the drug must be used for a medically accepted indication. (A “medically accepted indication” is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3 for more information about a medically accepted indication.)

- **This section is about your Part D drugs only.** To keep things simple, we generally say “drug” in the rest of this section, instead of repeating “covered outpatient prescription drug” or “Part D drug” every time.
- For details about what we mean by Part D drugs, the *List of Covered Drugs (Formulary)*, rules and restrictions on coverage, and cost information, see Chapter 5 (*Using our plan’s coverage for your Part D prescription drugs*).

Part D coverage decisions and appeals

As discussed in Section 5 of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

Legal Terms
An initial coverage decision about your Part D drugs is called a “ coverage determination. ”

Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including:

- Asking us to cover a Part D drug that is not on the plan’s *List of Covered Drugs (Formulary)*
- Asking us to waive a restriction on the plan’s coverage for a drug (such as limits on the amount of the drug you can get)
- You ask us whether a drug is covered for you and whether you meet the requirements for coverage. (For example, when your drug is on the plan’s *List of Covered Drugs (Formulary)* but we require you to get approval from us before we will cover it for you.)
 - *Please note:* If your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal. Use the chart below to help you determine which part has information for your situation:

Which of these situations are you in?

If you are in this situation:	This is what you can do:
Do you need a drug that isn’t on our Drug List or need us to waive a rule or restriction on a drug we cover?	You can ask us to make an exception. (This is a type of coverage decision.) Start with Section 7.2 of this chapter.
Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?	You can ask us for a coverage decision. Skip ahead to Section 7.4 of this chapter.
Do you want to ask us to pay you back for a drug you have already received and paid for?	You can ask us to pay you back. (This is a type of coverage decision.) Skip ahead to Section 7.4 of this chapter.
Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?	You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to Section 7.5 of this chapter.

Section 7.2 What is an exception?

If a drug is not covered in the way you would like it to be covered, you can ask us to make an “exception.” An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are two examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on our *List of Covered Drugs (Formulary)*.** (We call it the “Drug List” for short.)

Legal Terms

Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a “**formulary exception.**”

2. **Removing a restriction on our coverage for a covered drug.** There are extra rules or restrictions that apply to certain drugs on our *List of Covered Drugs (Formulary)* (for more information, go to Chapter 5 and look for Section 4).

Legal Terms

Asking for removal of a restriction on coverage for a drug is sometimes called asking for a “**formulary exception.**”

- The extra rules and restrictions on coverage for certain drugs include:
 - *Being required to use the generic version* of a drug instead of the brand name drug.
 - *Getting plan approval in advance* before we will agree to cover the drug for you. (This is sometimes called “prior authorization.”)
 - *Being required to try a different drug first* before we will agree to cover the drug you are asking for. (This is sometimes called “step therapy.”)
 - *Quantity limits.* For some drugs, there are restrictions on the amount of the drug you can have.

Section 7.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called “alternative” drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. Section 7.5 tells how to make an appeal if we say no.

The next section tells you how to ask for a coverage decision, including an exception.

Section 7.4 Step-by-step: How to ask for a coverage decision, including an exception

Step 1: You ask us to make a coverage decision about the drug(s) or payment you need. If your health requires a quick response, you must ask us to make a “**fast coverage decision.**” **You cannot ask for a fast coverage decision if you are asking us to pay you back for a drug you already bought.**

What to do

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can also access the coverage decision process through our website. For the details, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision about your Part D prescription drugs.* Or if you are asking us to pay you back for a drug, go to the section called, *Where to send a request that asks us to pay for our share of the cost for medical care or a drug you have received.*
- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. Section 5 of this chapter tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.

- **If you want to ask us to pay you back for a drug**, start by reading Chapter 6 of this booklet: *Asking us to pay a bill you have received for covered medical services or drugs*. Chapter 6 describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- **If you are requesting an exception, provide the “supporting statement.”** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the “supporting statement.”) Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See Sections 6.2 and 6.3 for more information about exception requests.
- **We must accept any written request**, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.

If your health requires it, ask us to give you a “fast coverage decision”

Legal Terms
A “fast coverage decision” is called an “expedited coverage determination.”

- When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. A standard coverage decision means we will give you an answer within 72 hours after we receive your doctor’s statement. A fast coverage decision means we will answer within 24 hours.
- **To get a fast coverage decision, you must meet two requirements:**
 - You can get a fast coverage decision *only* if you are asking for a *drug you have not yet received*. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you have already bought.)
 - You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor or other prescriber tells us that your health requires a “fast coverage decision,” we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own (without your doctor’s or other prescriber’s support), we will decide whether your health requires that we give you a fast coverage decision.
 - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
 - This letter will tell you that if your doctor or other prescriber asks for the fast coverage decision, we will automatically give a fast coverage decision.

- The letter will also tell how you can file a complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. It tells how to file a “fast” complaint, which means you would get our answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see Section 11 of this chapter.)

Step 2: We consider your request and we give you our answer.

Deadlines for a “fast” coverage decision

- If we are using the fast deadlines, we must give you our answer **within 24 hours**.
 - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor’s statement supporting your request. We will give you our answer sooner if your health requires us to.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor’s statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Deadlines for a “standard” coverage decision about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer **within 72 hours**.
 - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor’s statement supporting your request. We will give you our answer sooner if your health requires us to.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.

- **If our answer is yes to part or all of what you requested –**
 - If we approve your request for coverage, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor’s statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Deadlines for a “standard” coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Step 3: If we say no to your coverage request, you decide if you want to make an appeal.

- If we say no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made.

Section 7.5	Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan)
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Legal Terms

An appeal to the plan about a Part D drug coverage decision is called a plan “ redetermination. ”
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Step 1: You contact us and make your Level 1 Appeal. If your health requires a quick response, you must ask for a “**fast appeal.**”

What to do

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact us.**

- For details on how to reach us by phone, fax, or mail, or on our website, for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called, *How to contact us when you are making an appeal about your Part D prescription drugs.*
- **If you are asking for a standard appeal, make your appeal by submitting a written request.**
- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown in Chapter 2, Section 1** (How to contact our plan when you are making an appeal about your part D prescription drugs).
- **We must accept any written request**, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.**
 - You have the right to ask us for a copy of the information regarding your appeal.
 - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a “fast appeal”

Legal Terms
A “fast appeal” is also called an “expedited redetermination.”

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a “fast appeal.”
- The requirements for getting a “fast appeal” are the same as those for getting a “fast coverage decision” in Section 7.4 of this chapter.

Step 2: We consider your appeal and we give you our answer.

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the

rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a “fast” appeal

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires it.
 - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

Deadlines for a “standard” appeal

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for “fast” appeal.
 - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested –**
 - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we receive your appeal.
 - If we approve a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive your appeal request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

Step 3: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal.

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

Section 7.6 Step-by-step: How to make a Level 2 Appeal

If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms

The formal name for the “Independent Review Organization” is the “**Independent Review Entity.**” It is sometimes called the “**IRE.**”

Step 1: To make a Level 2 Appeal, you (or your representative or your doctor or other prescriber) must contact the Independent Review Organization and ask for a review of your case.

- If we say no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.
- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your “case file.” **You have the right to ask us for a copy of your case file.**
- You have a right to give the Independent Review Organization additional information to support your appeal.

Step 2: The Independent Review Organization does a review of your appeal and gives you an answer.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with us.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

Deadlines for “fast” appeal at Level 2

- If your health requires it, ask the Independent Review Organization for a “fast appeal.”
- If the review organization agrees to give you a “fast appeal,” the review organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.
- **If the Independent Review Organization says yes to part or all of what you requested**, we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

Deadlines for “standard” appeal at Level 2

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal.
- **If the Independent Review Organization says yes to part or all of what you requested** –
 - If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
 - If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. (This is called “upholding the decision.” It is also called “turning down your appeal.”)

To continue and make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

Step 3: If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and

make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.

- The Level 3 Appeal is handled by an administrative law judge. Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about our coverage for your hospital care, including any limitations on this coverage, see Chapter 4 of this booklet: *Benefits Chart (what is covered)*.

During your hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for care you may need after you leave.

- The day you leave the hospital is called your “**discharge date**.” Our plan’s coverage of your hospital stay ends on this date.
- When your discharge date has been decided, your doctor or the hospital staff will let you know.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This section tells you how to ask.

Section 8.1 **During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights**

During your hospital stay, you will be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call Customer Relations (phone numbers are printed on the back cover of this booklet). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

1. Read this notice carefully and ask questions if you don't understand it. It tells you about your rights as a hospital patient, including:

- Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be involved in any decisions about your hospital stay, and know who will pay for it.
- Where to report any concerns you have about quality of your hospital care.
- Your right to appeal your discharge decision if you think you are being discharged from the hospital too soon.

Legal Terms

The written notice from Medicare tells you how you can “**request an immediate review.**” Requesting an immediate review is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time. (Section 8.2 below tells you how you can request an immediate review.)

2. You must sign the written notice to show that you received it and understand your rights.

- You or someone who is acting on your behalf must sign the notice. (Section 5 of this chapter tells how you can give written permission to someone else to act as your representative.)
- Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice **does not mean** you are agreeing on a discharge date.

3. **Keep your copy** of the signed notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.
 - If you sign the notice more than 2 days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
 - To look at a copy of this notice in advance, you can call Customer Relations (phone numbers are printed on the back cover of this booklet) or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see it online at http://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp.

Section 8.2	Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date
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If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Relations (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

Step 1: Contact the Quality Improvement Organization in your state and ask for a “fast review” of your hospital discharge. You must act quickly.

A “fast review” is also called an “immediate review.”

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care professionals who are paid by the Federal government. These experts are not part of our plan. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare.

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than your planned discharge date**. (Your “planned discharge date” is the date that has been set for you to leave the hospital.)
 - If you meet this deadline, you are allowed to stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision on your appeal from the Quality Improvement Organization.
 - If you do *not* meet this deadline, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 8.4.

Ask for a “fast review”:

- You must ask the Quality Improvement Organization for a **“fast review”** of your discharge. Asking for a “fast review” means you are asking for the organization to use the “fast” deadlines for an appeal instead of using the standard deadlines.

Legal Terms
A “fast review” is also called an “immediate review” or an “expedited review.”

Step 2: The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them “the reviewers” for short) will ask you (or your representative) why you believe coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.

- By noon of the day after the reviewers informed our plan of your appeal, you will also get a written notice that gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Legal Terms

This written explanation is called the “**Detailed Notice of Discharge.**” You can get a sample of this notice by calling Customer Relations (phone numbers are printed on the back cover of this booklet) or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at <http://www.cms.hhs.gov/BNI/>

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the review organization says *yes* to your appeal, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See Chapter 4 of this booklet).

What happens if the answer is no?

- If the review organization says *no* to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the review organization says *no* to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to “Level 2” of the appeals process.

Section 8.3	Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date
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If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day when the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 calendar days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

- It means they agree with the decision they made on your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 8.4 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 8.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. (“Quickly” means before you leave the hospital and no later than your planned discharge date.) If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 Alternate Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Legal Terms

A “fast” review (or “fast appeal”) is also called an “**expedited appeal**”.

Step 1: Contact us and ask for a “fast review.”

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are making an appeal about your medical care.*

- **Be sure to ask for a “fast review.”** This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines.

Step 2: We do a “fast” review of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- In this situation, we will use the “fast” deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: We give you our decision within 72 hours after you ask for a “fast review” (“fast appeal”).

- **If we say yes to your fast appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered inpatient hospital services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
 - If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

Step 4: If we say *no* to your fast appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the “Independent Review Organization.”** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: How to make a Level 2 *Alternate Appeal*

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your “fast appeal.” This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the “Independent Review Organization” is the “ Independent Review Entity. ” It is sometimes called the “ IRE. ”

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 11 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says *yes* to your appeal,** then we must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan’s coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with us that your planned hospital discharge date was medically appropriate.

- The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 9.1	<i>This section is about three services only: Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services</i>
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This section is about the following types of care *only*:

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a “skilled nursing facility,” see Chapter 11, *Definitions of important words*.)
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 11, *Definitions of important words*.)

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see Chapter 4 of this booklet: *Benefits Chart (what is covered)*.

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *we will stop paying for your care*.

If you think we are ending the coverage of your care too soon, **you can appeal our decision.** This section tells you how to ask for an appeal.

Section 9.2 We will tell you in advance when your coverage will be ending

- 1. You receive a notice in writing.** At least two days before our plan is going to stop covering your care, the agency or facility that is providing your care will give you a notice.
 - The written notice tells you the date when we will stop covering the care for you.
 - The written notice also tells what you can do if you want to ask our plan to change this decision about when to end your care, and keep covering it for a longer period of time.

Legal Terms

In telling you what you can do, the written notice is telling how you can request a **“fast-track appeal.”** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. (Section 9.3 below tells how you can request a fast-track appeal.)

The written notice is called the **“Notice of Medicare Non-Coverage.”** To get a sample copy, call Customer Relations (phone numbers are printed on the back cover of this booklet) or 1-800-MEDICARE (1-800-633-4227, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.). Or see a copy online at <http://www.cms.hhs.gov/BNI/>

- 2. You must sign the written notice to show that you received it.**
 - You or someone who is acting on your behalf must sign the notice. (Section 5 tells how you can give written permission to someone else to act as your representative.)
 - Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with the plan that it’s time to stop getting the care.

Section 9.3 Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 11 of this chapter tells you how to file a complaint.)
- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Relations (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.

Step 1: Make your Level 1 Appeal: contact the Quality Improvement Organization in your state and ask for a review. You must act quickly.

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care experts who are paid by the Federal government. These experts are not part of our plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of medical care.

How can you contact this organization?

- The written notice you received tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

What should you ask for?

- Ask this organization to do an independent review of whether it is medically appropriate for us to end coverage for your medical services.

Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal *no later than noon of the day after you receive the written notice telling you when we will stop covering your care.*
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see Section 9.5.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them “the reviewers” for short) will ask you (or your representative) why you believe coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers informed us of your appeal, and you will also get a written notice from us that explains in detail our reasons for ending our coverage for your services.

Legal Terms
This notice explanation is called the “ Detailed Explanation of Non-Coverage. ”

Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.

What happens if the reviewers say yes to your appeal?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see Chapter 4 of this booklet).

What happens if the reviewers say no to your appeal?

- If the reviewers say *no* to your appeal, then **your coverage will end on the date we have told you.** We will stop paying its share of the costs of this care.
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- This first appeal you make is “Level 1” of the appeals process. If reviewers say *no* to your Level 1 Appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make another appeal.
- Making another appeal means you are going on to “Level 2” of the appeals process.

Section 9.4	Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time
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If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes to your appeal?

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision we made to your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 9.5 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 9.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 Alternate Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Here are the steps for a Level 1 Alternate Appeal:

Legal Terms

A “fast” review (or “fast appeal”) is also called an “**expedited appeal**”.

Step 1: Contact us and ask for a “fast review.”

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are making an appeal about your medical care.*

- **Be sure to ask for a “fast review.”** This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines.

Step 2: We do a “fast” review of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan’s coverage for services you were receiving.
- We will use the “fast” deadlines rather than the standard deadlines for giving you the answer to this review. (Usually, if you make an appeal to our plan and ask for a “fast review,” we are allowed to decide whether to agree to your request and give you a “fast review.” But in this situation, the rules require us to give you a fast response if you ask for it.)

Step 3: We give you our decision within 72 hours after you ask for a “fast review” (“fast appeal”).

- **If we say yes to your fast appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal,** then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end, then **you will have to pay the full cost** of this care yourself.

Step 4: If we say *no* to your fast appeal, your case will *automatically* go on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the “Independent Review Organization.”** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: How to make a Level 2 *Alternate Appeal*

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your “fast appeal.” This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the “Independent Review Organization” is the “ Independent Review Entity. ” It is sometimes called the “ IRE. ”

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 11 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- **If this organization says *yes* to your appeal,** then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.

- The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 10 Taking your appeal to Level 3 and beyond

Section 10.1 Levels of Appeal 3, 4, and 5 for Medical Service Appeals
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This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal A judge who works for the Federal government will review your appeal and give you an answer. This judge is called an “Administrative Law Judge.”
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- **If the Administrative Law Judge says yes to your appeal, the appeals process *may* or *may not* be over** - We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
 - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the judge’s decision.
 - If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.

- **If the Administrative Law Judge says no to your appeal, the appeals process *may* or *may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal The **Appeals Council** will review your appeal and give you an answer. The Appeals Council works for the Federal government.

- **If the answer is yes, or if the Appeals Council denies our request to review a favorable Level 3 Appeal decision, the appeals process *may* or *may not* be over** - We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you.
 - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Appeals Council's decision.
 - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Appeals Council denies the review request, the appeals process *may* or *may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Appeals Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal A judge at the **Federal District Court** will review your appeal.

- This is the last step of the administrative appeals process.

Section 10.2 Levels of Appeal 3, 4, and 5 for Part D Drug Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The

written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal A judge who works for the Federal government will review your appeal and give you an answer. This judge is called an “Administrative Law Judge.”

- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may or may not be over.***
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal The Appeals Council will review your appeal and give you an answer. The Appeals Council works for the Federal government.

- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Appeals Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may or may not be over.***
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Appeals Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal A judge at the Federal District Court will review your appeal.

- This is the last step of the appeals process.

SECTION 11 How to make a complaint about quality of care, waiting times, customer service, or other concerns



If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to Section 5 of this chapter.

Section 11.1 What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only*. This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

If you have any of these kinds of problems, you can “make a complaint”

Complaint	Example
Quality of your medical care	<ul style="list-style-type: none"> • Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	<ul style="list-style-type: none"> • Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
Disrespect, poor customer service, or other negative behaviors	<ul style="list-style-type: none"> • Has someone been rude or disrespectful to you? • Are you unhappy with how our Customer Relations has treated you? • Do you feel you are being encouraged to leave the plan?
Waiting times	<ul style="list-style-type: none"> • Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Customer Relations or other staff at the plan? <ul style="list-style-type: none"> ○ Examples include waiting too long on the phone, in the waiting room, when getting a prescription, or in the exam room.
Cleanliness	<ul style="list-style-type: none"> • Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor’s office?
Information you get from us	<ul style="list-style-type: none"> • Do you believe we have not given you a notice that we are required to give? • Do you think written information we have given you is hard to understand?
<p>Timeliness (These types of complaints are all related to the <i>timeliness</i> of our actions related to coverage decisions and appeals)</p>	<p>The process of asking for a coverage decision and making appeals is explained in sections 4-10 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.</p> <p>However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:</p> <ul style="list-style-type: none"> • If you have asked us to give you a “fast coverage decision” or a “fast appeal, and we have said we will not, you can make a complaint. • If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint. • When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services or drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint. • When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 11.2 **The formal name for “making a complaint” is “filing a grievance”**

Legal Terms

- What this section calls a “**complaint**” is also called a “**grievance.**”
- Another term for “**making a complaint**” is “**filing a grievance.**”
- Another way to say “**using the process for complaints**” is “**using the process for filing a grievance.**”

Section 11.3 **Step-by-step: Making a complaint**

Step 1: Contact us promptly – either by phone or in writing.

Usually, calling Customer Relations is the first step. If there is anything else you need to do, Customer Relations will let you know. Call Customer Relations at 1-855-670-5934 (TTY 1-855-670-5936). Representatives are available Monday – Friday, 8:00 a.m. – 8:00 p.m. (From Oct. 1 – Feb. 14 representatives are available 7 days a week, 8:00 a.m. – 8:00 p.m.).

- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.

You need to file a grievance no later than 60 days after the event whether you file orally or in writing. You can do so by calling Customer Relations at 1-855-670-5934 (TTY 1-855-670-5936), Representatives are available Monday – Friday, 8:00 a.m. – 8:00 p.m. (From October 1 – 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. You can also file a grievance in writing by sending it by mail to: Tufts Health Plan Medicare Preferred, Attn: Appeals & Grievances Department, 705 Mt. Auburn Street, Watertown, MA 02472. You can also send it in writing via fax at: 1-(617) 972-9516.

You also have the right to file an expedited Grievance which could include a complaint that Tufts Health Plan Medicare Preferred refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration time frame(s). The time frame for Tufts Health Plan Medicare Preferred to respond is within 24 hours of your complaint.

- **Whether you call or write, you should contact Customer Relations right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we will automatically give you a “fast” complaint.** If you have a “fast” complaint, it means we will give you **an answer within 24 hours.**

Legal Terms
What this section calls a “fast complaint” is also called an “expedited grievance.”

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint.
- **If we do not agree** with some or all of your complaint or don’t take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 11.4	You can also make complaints about quality of care to the Quality Improvement Organization
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You can make your complaint about the quality of care you received to us by using the step-by-step process outlined above.

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).
 - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

- To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

Section 11.5 You can also tell Medicare about your complaint

You can submit a complaint about Tufts Health Plan Senior Care Options directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

Section 11.6 Complaints about mental health parity

Federal and state laws require that all managed care organizations, including Tufts Health Plan Senior Care Options, provide behavioral health services to MassHealth Standard (Medicaid) members in the same way they provide physical health services. This is what is referred to as “parity”. In general, this means that:

1. Tufts Health Plan Senior Care Options must provide the same level of benefits for any mental health and substance abuse problems you may have as for other physical problems you may have;
2. Tufts Health Plan Senior Care Options must have similar prior authorization requirements and treatment limitations for mental health and substance abuse services as it does for physical health services;
3. Tufts Health Plan Senior Care Options must provide you or your provider with the medical necessity criteria used by Tufts Health Plan Senior Care Options for prior authorization upon your or your provider’s request; and
4. Tufts Health Plan Senior Care Options must also provide you within a reasonable time frame the reason for any denial of authorization for mental or substance abuse services.

If you think that Tufts Health Plan Senior Care Options is not providing parity as explained above, you have the right to file a Grievance with Tufts Health Plan Senior Care Options. For more information about Grievances and how to file them, please review the section on how to make a complaint earlier in this chapter.

You may also file a grievance with MassHealth Standard (Medicaid). You can do this by calling the MassHealth Standard (Medicaid) Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648) Monday—Friday 8:00 a.m. to 5:00 p.m.

PROBLEMS ABOUT YOUR MASSHEALTH STANDARD (MEDICAID) BENEFITS

SECTION 12 Handling problems about your MassHealth Standard (Medicaid) benefits

Your MassHealth Standard (Medicaid) Appeal and Grievance Rights Appeals

You may pursue a MassHealth Board of Hearings (BOH) review, in addition to, or instead of, filing a standard or expedited appeal with Tufts Health Plan Senior Care Options.

If you choose to pursue an external appeal, you must submit your written hearing request to BOH within 30 calendar days from the date of mailing of the Tufts Health Plan Senior Care Options notice to deny coverage for your services. The Tufts Health Plan Senior Care Options Appeals and Grievances Department may assist you with this process. Hearing requests should be sent to:

Executive Office of Health and Human Services
Board of Hearings
Office of Medicaid
100 Hancock Street, 6th floor
Quincy, MA 02171
Or fax to 1-617-847-1204

If applicable, you can choose to continue receiving requested services from Tufts Health Plan Senior Care Options during the standard or expedited appeal process. If you want to receive such continuing services, you or your authorized appeal representative must submit your appeal request within ten (10) calendar days from the date of the letter notifying you of denial and indicate that you want to continue to get these services.

If the outcome of the external review is not in your favor, you will not be financially responsible for the services provided.

If you disagree with the BOH decision, there are further levels of appeals available to you, including judicial review of the decision under Massachusetts General Law. To do so, you need to complete another Fair Hearing Request form, which you will receive with the Appeal determination letter and mail or fax it back to the same address as above.

To ask for help with any of the Appeals process options, call Customer Relations at 855-670-5934 (TTY: 855-670-5936). Representatives are available Monday – Friday, 8:00 a.m. – 8:00 p.m. (From Oct. 1 – Feb. 14 representatives are available 7 days a week, 8:00 a.m. – 8:00 p.m.).

Chapter 9. Ending your membership in the plan

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SECTION 1 Introduction

Section 1.1	This chapter focuses on ending your membership in our plan
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Ending your membership in Tufts Health Plan Senior Care Options may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave.
 - You can end your membership in the plan at any time. Section 2 tells you about the types of plans you can enroll in and when your enrollment in your new coverage will begin.
 - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your medical care through our plan until your membership ends.

SECTION 2 When can you end your membership in our plan?

Section 2.1	You can end your membership at any time
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You can end your membership in Tufts Health Plan Senior Care Options at any time.

- **When can you end your membership?** Most people with Medicare can end their membership only during certain times of the year. However, because you get assistance from MassHealth Standard (Medicaid), **you can end your membership in Tufts Health Plan Senior Care Options at any time.**
- **What type of plan can you switch to?** If you decide to change to a new plan, you can choose any of the following types of Medicare plans:
 - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
 - Original Medicare *with* a separate Medicare prescription drug plan.
 - If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Note: If you disenroll from Medicare prescription drug coverage and go without “creditable” prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. (“Creditable” coverage means the coverage is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.)

Contact your State MassHealth Standard (Medicaid) Office to learn about your MassHealth Standard (Medicaid) plan options (telephone numbers are in Chapter 2, Section 6 of this booklet).

- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plans. Your enrollment in your new plan will also begin on this day.

Section 2.2	Where can you get more information about when you can end your membership?
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If you have any questions or would like more information on when you can end your membership:

- You can **call Customer Relations** (phone numbers are printed on the back cover of this booklet).
- You can find the information in the *Medicare & You 2015* Handbook.
 - Everyone with Medicare receives a copy of *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.
 - You can also download a copy from the Medicare website (<http://www.medicare.gov>). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 3 **How do you end your membership in our plan?**

Section 3.1	Usually, you end your membership by enrolling in another plan
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Usually, to end your membership in our plan, you simply enroll in another Medicare plan. However, if you want to switch from our plan to Original Medicare but you have not selected a separate Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Customer Relations if you need more information on how to do this (phone numbers are printed on the back cover of this booklet).

- --or--You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	This is what you should do:
<ul style="list-style-type: none"> • Another Medicare health plan. 	<ul style="list-style-type: none"> • Enroll in the new Medicare health plan. You will automatically be disenrolled from Tufts Health Plan Senior Care Options when your new plan’s coverage begins.
<ul style="list-style-type: none"> • Original Medicare <i>with</i> a separate Medicare prescription drug plan. 	<ul style="list-style-type: none"> • Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from Tufts Health Plan Senior Care Options when your new plan’s coverage begins.
<ul style="list-style-type: none"> • Original Medicare <i>without</i> a separate Medicare prescription drug plan. <ul style="list-style-type: none"> ○ If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment. ○ If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. 	<ul style="list-style-type: none"> • Send us a written request to disenroll. Contact Customer Relations if you need more information on how to do this (phone numbers are printed on the back cover of this booklet). • You can also contact Medicare, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from Tufts Health Plan Senior Care Options when your coverage in Original Medicare begins.

SECTION 4 Until your membership ends, you must keep getting your medical services and drugs through our plan

Section 4.1 Until your membership ends, you are still a member of our plan
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If you leave Tufts Health Plan Senior Care Options, it may take time before your membership ends and your new Medicare and MassHealth Standard (Medicaid) coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care and prescription drugs through our plan.

- **You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy including through our mail-order pharmacy services.
- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 Tufts Health Plan Senior Care Options must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

Tufts Health Plan Senior Care Options **must end your membership in the plan if any of the following happen:**

- If you do not stay continuously enrolled in Medicare Part A and Part B.
- If you are no longer eligible for MassHealth Standard (Medicaid). As stated in Chapter 1, section 2.1, our plan is for people who are eligible for both Medicare and MassHealth Standard (Medicaid). If you lose eligibility for MassHealth Standard (Medicaid) benefits, Tufts Health Plan Senior Care Options will continue to provide care as long as you can reasonably be expected to regain your MassHealth Standard (Medicaid) coverage within two months. We will continue your membership for the remainder of the month in which we receive notification from MassHealth (Medicaid) about your loss of eligibility, along with two additional calendar months. If you regain your MassHealth Standard (Medicaid) coverage during this period, we will not end your membership.
- If you move out of our service area.
- If you are away from our service area for more than six months.

- If you move or take a long trip, you need to call Customer Relations to find out if the place you are moving or traveling to is in our plan's area. (Phone numbers for Customer Relations are printed on the back cover of this booklet.)
- If you become incarcerated (go to prison).
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
 - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan.

Where can you get more information?

If you have questions or would like more information on when we can end your membership:

- You can call **Customer Relations** for more information (phone numbers are printed on the back cover of this booklet).

Section 5.2	We <u>cannot</u> ask you to leave our plan for any reason related to your health
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Tufts Health Plan Senior Care Options is not allowed to ask you to leave our plan for any reason related to your health.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Section 5.3	You have the right to make a complaint if we end your membership in our plan
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If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can make a complaint about our decision to end your membership. You can also look in Chapter 8, Section 11 for information about how to make a complaint.

Chapter 10. Legal notices

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SECTION 1 Notice about governing law

Many laws apply to this *Evidence of Coverage* and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage Plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Tufts Health Plan, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

SECTION 4 Notice about the relationship between Tufts Health Plan Senior Care Options and providers

Tufts Health Plan Senior Care Options arranges health care services. Tufts Health Plan Senior Care Options has contractual agreements with providers practicing in their private offices throughout the service area. These providers are independent. They are not Tufts Health Plan Senior Care Options employees or representatives. Providers are not authorized to change this Evidence of Coverage or assume or create any obligation for Tufts Health Plan Senior Care Options that is inconsistent with this Evidence of Coverage.

Chapter 11. Definitions of important words

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for a drug, item, or service you think you should be able to receive. Chapter 8 explains appeals, including the process involved in making an appeal.

Benefit Period – The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent \$4,700 in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

Coinsurance – An amount you may be required to pay as your share of the cost for services or prescription drugs. Coinsurance is usually a percentage (for example, 20%). Members of Tufts Health Plan Senior Care Options do not pay for coinsurance for covered services or drugs.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay \$10 or

\$20 for a doctor's visit or prescription drug. Members of Tufts Health Plan Senior Care Options do not have copayments for covered services or drugs.

Cost-sharing – Cost-sharing refers to amounts that a member has to pay when services or drugs are received. Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed “copayment” amount that a plan requires when a specific service or drug is received; or (3) any “coinsurance” amount, a percentage of the total amount paid for a service or drug, that a plan requires when a specific service or drug is received. A “daily cost-sharing rate” may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copay. Members of Tufts Health Plan Senior Care Options do not have cost sharing for covered services or drugs.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of 5 cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called “coverage decisions” in this booklet. Chapter 8 explains how to ask us for a coverage decision.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

Covered Services – The general term we use to mean all of the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care is personal care that can be provided by people who don't have professional skills or training, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Customer Relations – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Customer Relations.

Daily cost-sharing rate – A “daily cost-sharing rate” may apply when your doctor prescribes less than a full month’s supply of certain drugs for you and you are required to pay a copay. A daily cost-sharing rate is the copay divided by the number of days in a month’s supply. Here is an example: If your copay for a one-month supply of a drug is \$30, and a one-month’s supply in your plan is 30 days, then your “daily cost-sharing rate” is \$1 per day. This means you pay \$1 for each day’s supply when you fill your prescription.

Deductible – The amount you must pay for health care or prescriptions before our plan begins to pay. Members of Tufts Health Plan Senior Care Options do not have deductibles for covered services or drugs.

Disenroll or Disenrollment – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs such as the pharmacist’s time to prepare and package the prescription.

Dual Eligible Individual – A person who qualifies for Medicare and MassHealth Standard (Medicaid) coverage.

Durable Medical Equipment – Certain medical equipment that is ordered by your doctor for medical reasons. Examples are walkers, wheelchairs, or hospital beds.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care – Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor’s formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a “generic” drug works the same as a brand name drug and usually costs less.

Grievance - A type of complaint you make about us or one of our network providers or pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Home Health Aide – A home health aide provides services that don’t need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Hospice - An enrollee who has 6 months or less to live has the right to elect hospice. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer. The hospice will provide special treatment for your state.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.”

Income Related Monthly Adjustment Amount (IRMAA) – If your income is above a certain limit, you will pay an income-related monthly adjustment amount in addition to your plan premium. For example, individuals with income greater than \$85,000 and married couples with income greater than \$170,000 must pay a higher Medicare Part B (medical insurance) and Medicare prescription drug coverage premium amount. This additional amount is called the income-related monthly adjustment amount. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Initial Coverage Limit – The maximum limit of coverage under the Initial Coverage Stage.

Initial Coverage Stage – This is the stage before your total drug costs including amounts you have paid and what your plan has paid on your behalf for the year have reached \$2,960.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. For example, if you’re eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Institutional Special Needs Plan (SNP) – A Special Needs Plan that enrolls eligible individuals who continuously reside or are expected to continuously reside for 90 days or longer in a long-term care (LTC) facility. These LTC facilities may include a skilled nursing facility (SNF); nursing facility (NF); (SNF/NF); an intermediate care facility for the mentally retarded (ICF/MR); and/or an inpatient psychiatric facility. An institutional Special Needs Plan to serve Medicare residents of LTC facilities must have a contractual arrangement with (or own and operate) the specific LTC facility (ies).

Institutional Equivalent Special Needs Plan (SNP) – An institutional Special Needs Plan that enrolls eligible individuals living in the community but requiring an institutional level of care based on the State assessment. The assessment must be performed using the same respective State level of care assessment tool and administered by an entity other than the organization offering the plan. This type of Special Needs Plan may restrict enrollment to individuals that reside in a contracted assisted living facility (ALF) if necessary to ensure uniform delivery of specialized care.

Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive “Extra Help” from Medicare to pay your prescription drug plan costs, you will not pay a late enrollment penalty.

If you ever lose your low income subsidy (“Extra Help”), you must maintain your Part D coverage or you could be subject to a late enrollment penalty if you ever chose to enroll in Part D in the future.

List of Covered Drugs (Formulary or “Drug List”) – A list of prescription drugs covered by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand name and generic drugs.

Low Income Subsidy (LIS) – See “Extra Help.”

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for covered Part A and Part B services. You must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by MassHealth Standard (Medicaid) or another third party) Amounts you pay for your Medicare Part A and Part B premiums do not count toward the maximum out-of-pocket amount. (Note: Because our members also get assistance from MassHealth Standard (Medicaid), very few members ever reach this out-of-pocket maximum.)

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3 for more information about a medically accepted indication.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a Medicare Advantage Plan.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand name drugs to Part D enrollees who have reached the Coverage Gap Stage and who are not already receiving “Extra Help.” Discounts are based on agreements between the Federal government and certain drug manufacturers. For this reason, most, but not all, brand name drugs are discounted.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and B.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

“Medigap” (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill “gaps” in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or “Plan Member”) – A person with Medicare who is eligible to get covered services, who has enrolled in our plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Customer Relations – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Customer Relations.

Network Pharmacy – A network pharmacy is a pharmacy where members of our plan can get their prescription drug benefits. We call them “network pharmacies” because they contract with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider – “Provider” is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them “**network providers**” when they have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Our plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as “plan providers.”

Organization Determination – The Medicare Advantage plan has made an organization determination when it makes a decision about whether items or services are covered or how much you have to pay for covered items or services. The Medicare Advantage plan’s network provider or facility has also made an organization determination when it provides you with an item or service, or refers you to an out-of-network provider for an item or service. Organization determinations are called “coverage decisions” in this booklet. Chapter 8 explains how to ask us for a coverage decision.

Original Medicare (“Traditional Medicare” or “Fee-for-service” Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that doesn’t have a contract with our plan to coordinate or provide covered drugs to members of our plan. As explained in this Evidence of Coverage, most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan or are not

under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

Out-of-Pocket Costs – See the definition for “cost-sharing” above. A member’s cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member’s “out-of-pocket” cost requirement.

Part C – see “**Medicare Advantage (MA) Plan.**”

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost-sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Primary Care Physician (PCP) – Your Primary Care Physician is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your Primary Care Physician before you see any other health care provider. See Chapter 3, Section 2.1 for information about Primary Care Physicians.

Prior Authorization – Approval in advance to get services or certain drugs that may or may not be on our formulary. Some in-network medical services are covered only if your doctor or other network provider gets “prior authorization” from our plan. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4. Some drugs are covered only if your doctor or other network provider gets “prior authorization” from us. Covered drugs that need prior authorization are marked in the formulary.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Referral – An approval from a member’s PCP to seek care from another health care professional, usually a specialist, for treatment or consultation.

Referral Circle – Each plan PCP has certain plan specialists called a “referral circle” that she or he uses for providing medical care to you. This means that in most cases, you will not have access to the entire Tufts Health Plan Senior Care Options network, except in emergency or urgent care situations or for out-of-area renal dialysis or other services.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Service Area – A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it’s also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you permanently move out of the plan’s service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and MassHealth Standard (Medicaid), who reside in a nursing home, or who have certain chronic medical conditions.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Care – Urgently needed care is care provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed care may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.

Appendix 1. Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-855-670-5934. Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-855-670-5934. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电1-855-670-5934。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電1-855-670-5934。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-855-670-5934. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-855-670-5934. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-855-670-5934 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-855-670-5934. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-855-670-5934번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-855-670-5934. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على بمساعدتك. هذه خدمة . سيقوم شخص ما يتحدث العربية 1-855-670-5934 مترجم فوري، ليس عليك سوى الاتصال بنا على مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-855-670-5934 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-855-670-5934. Un nostro incaricato che parla Italiano vi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-855-670-5934. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-855-670-5934. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-855-670-5934. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-855-670-5934にお電話ください。日本語を話す人 者が支援いたします。これは無料のサービスです。

Tufts Health Plan Senior Care Options Customer Relations

CALL	<p>1-855-670-5934</p> <p>Calls to this number are free. Representatives are available Monday – Friday, 8:00 a.m. – 8:00 p.m. (From Oct. 1 – Feb. 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.</p> <p>Customer Relations also has free language interpreter services available for non-English speakers.</p>
TTY	<p>1-855-670-5936</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free. Representatives are available Monday – Friday, 8:00 a.m. – 8:00 p.m. (From Oct. 1 – Feb. 14 representatives are available. After hours and on holidays, please leave a message and a representative will return your call on the next business day.</p>
FAX	1-617-972-9487
WRITE	<p>Tufts Health Plan Senior Care Options ATTN: Customer Relations P.O. Box 9181 Watertown, MA 02471-9181</p>
WEBSITE	www.thpmp.org/sco

SHINE (Serving Health Information Needs of Elders) Massachusetts SHIP

SHINE is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

CALL	1-800-243-4636 (1-800-AGE-INFO)
TTY	<p>1-800-872-0166</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p>
WRITE	Call the number above for the address of the SHINE program in your area.
WEBSITE	www.mass.gov