



a Point32Health company

January 1–December 31, 2025

Evidence of Coverage

Your Medicare Health Benefits and Services as a Member of:

Tufts Medicare Preferred HMO Basic No Rx (HMO)

This document gives you the details about your Medicare health care coverage from January 1 – December 31, 2025. **This is an important legal document. Please keep it in a safe place.**

For questions about this document, please contact Member Services at 1-800-701-9000 for additional information. (TTY users should call 711.) Hours are 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31 and Monday – Friday from April 1 to September 30. After hours and on holidays, please leave a message and a representative will return your call on the next business day. This call is free.

This plan, Tufts Medicare Preferred HMO Basic No Rx, is offered by Tufts Associated Health Maintenance Organization (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 Medicare Preferred HMO Basic No Rx.)

This document is available for free in Spanish.

This information is available in different formats, including large print.

Benefits, premiums, and/or copayments/coinsurance may change on January 1, 2026.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. We will notify affected enrollees about changes at least 30 days in advance.

This document explains your benefits and rights. Use this document to understand about:

- Your plan premium and cost sharing;
- Your medical benefits;
- How to file a complaint if you are not satisfied with a service or treatment;
- How to contact us if you need further assistance; and,
- Other protections required by Medicare law.

2025 Evidence of Coverage

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CHAPTER 1:

Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in Tufts Medicare Preferred HMO Basic No Rx, which is a Medicare HMO

You are covered by Medicare, and you have chosen to get your Medicare health care through our plan, Tufts Medicare Preferred HMO Basic No Rx. We are required to cover all Part A and Part B services. However, cost sharing and provider access in this plan differ from Original Medicare.

Tufts Medicare Preferred HMO Basic No Rx is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) approved by Medicare and run by a private company. Tufts Medicare Preferred HMO Basic No Rx does not include Part D prescription drug coverage.

Coverage under this Plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at: www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

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

This *Evidence of Coverage* document tells you how to get your medical care. It explains your rights and responsibilities, what is covered, and what you pay as a member of the plan, and how to file a complaint if you are not satisfied with a decision or treatment.

The words *coverage* and *covered services* refer to the medical care and services available to you as a member of Tufts Medicare Preferred HMO Basic No Rx.

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* document.

If you are confused or concerned or just have a question, please contact our plan's Member Services.

Section 1.3 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how Tufts Medicare Preferred HMO Basic No Rx covers your care. Other parts of this contract include your enrollment form 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 Medicare Preferred HMO Basic No Rx between January 1, 2025, and December 31, 2025.

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 Medicare Preferred HMO Basic No Rx after December 31, 2025. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2025.

Medicare (the Centers for Medicare & Medicaid Services) must approve Tufts Medicare Preferred HMO Basic No Rx 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

You are eligible for membership in our plan as long as:

- You have both Medicare Part A and Medicare Part B.
- -- and -- You live in our geographic service area (Section 2.2 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.
- -- and -- you are a United States citizen or are lawfully present in the United States.

Section 2.2 Here is the plan service area for Tufts Medicare Preferred HMO Basic No Rx

Tufts Medicare Preferred HMO Basic No Rx 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:

- Essex County
- Suffolk County
- Worcester County

If you plan to move out of the service area, you cannot remain a member of this plan. Please contact Member Services to see if we have a plan in your new area. 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 2.3 U.S. Citizen or Lawful Presence

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify Tufts Medicare Preferred HMO Basic No Rx if you are not eligible to remain a member on this basis. Tufts Medicare Preferred HMO Basic No Rx must disenroll you if you do not meet this requirement.

SECTION 3 Important membership materials you will receive

Section 3.1 Your plan membership card

While you are a member of our plan, you must use your membership card whenever you get services covered by this plan. You should also show the provider your Medicaid card, if applicable. Here's a sample membership card to show you what yours will look like:

 TUFTS Health Plan <small>a Point32Health company</small>	PLAN NAME Medical Plan	Copays \$XX PCP OV \$XX Spec OV \$XX ER
RxBIN 610011	RxPCN CTRXMEDD	
RxGRP RXMEDD	Plan (80840)	
ID S90000001	Issued: 01/01/2025	
Name FIRST A. LAST	CMS - H2256 - XXX	

IN AN EMERGENCY: If your life is in danger, call 911 or go to the nearest emergency room.

Member Services: 1-800-701-9000 (TTY: 711)

Provider Services: 1-800-279-9022

Send Medical Claims to: Tufts Health Plan, P.O. Box 518, Canton, MA 02021

Website: www.thmp.org

Do NOT use your red, white, and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your Tufts Medicare Preferred HMO Basic No Rx membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare-approved clinical research studies, also called clinical trials.

If your plan membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card.

Section 3.2 Provider Directory

The *Provider Directory* lists our current network providers and durable medical equipment suppliers. **Network providers** are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, 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.

You must use network providers to get your medical care and services. If you go elsewhere without proper authorization you will have to pay in full. The only exceptions are emergencies, urgently needed services when the network is not available (that is, in situations when it is unreasonable or not possible to obtain services in-network), out-of-area dialysis services, and cases in which Tufts Medicare Preferred HMO Basic No Rx authorizes use of out-of-network providers.

The most recent list of providers and suppliers is available on our website at www.thpmp.org.

If you don't have your copy of the *Provider Directory*, you can request a copy (electronically or in hardcopy form) from Member Services. Requests for hard copy *Provider Directories* will be mailed to you within three business days.

SECTION 4 Your monthly costs for Tufts Medicare Preferred HMO Basic No Rx

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Optional Supplemental Benefit Premium (Section 4.3)

Medicare Part B premiums differ for people with different incomes. If you have questions about these premiums review your copy of *Medicare & You 2025* handbook, the section called *2025 Medicare Costs*. If you need a copy you can download it from the Medicare website (www.medicare.gov/medicare-and-you). 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 4.1 Plan premium

As a member of our plan, you pay a monthly plan premium. The table below shows the monthly plan premium amount for each region we serve.

If you live in...	Tufts Medicare Preferred HMO Basic No Rx
Essex County	\$38.00
Suffolk County	\$38.00
Worcester County	\$30.00

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, **you must continue paying your Medicare premiums to remain a member of the plan.** This includes your premium for Part B. It may also include a premium for Part A which affects members who aren't eligible for premium-free Part A.

Section 4.3 Optional Supplemental Benefit Premium

If you signed up for extra benefits, also called *optional supplemental benefits*, then you pay an additional premium each month for these extra benefits. See Chapter 4, Section 2.2 for details. The additional monthly premium for adding the Tufts Medicare Preferred Dental Option to your plan is \$37.00. If you have any questions about your plan premiums, please call Member Services.

SECTION 5 More information about your monthly premium

Section 5.1 There are several ways you can pay your plan premium

There are 4 ways you can pay your plan premium.

Option 1: Paying by check

The monthly plan premium is due on the fifteenth (15th) of each month. If you choose to pay us directly, Tufts Medicare Preferred will send you an invoice and a return envelope as plan premiums come due. Please complete a check or money order for the amount shown on the invoice (checks/money orders must be made payable to Tufts Medicare Preferred) and mail to Tufts Medicare Preferred in the window envelope provided or to:

Tufts Medicare Preferred
PO Box 9225
Chelsea, MA 02150

Payments received will automatically be applied to the oldest outstanding invoice. Payments received by the due date will be reflected on the next month's invoice.

If you wish to drop off a check in person (Mon – Fri, 8 a.m. – 5 p.m.) please bring it to:

Tufts Medicare Preferred
1 Wellness Way
Canton, MA 02021

Option 2: Paying by using Electronic Funds Transfer (EFT)

Instead of paying by check, you can have your monthly plan premium paid by Electronic Funds Transfer (EFT). Automatic deductions from your bank account occur monthly and are generally made on the 9th of each month. The withdrawal takes place on the 9th in order to allow for payment to be received and posted to your account by the invoice due date of the 15th. If the 9th falls on a Saturday, Sunday, or a holiday, the deduction will occur on the following business day. If you would like to pay your monthly plan premium by EFT and aren't currently doing so, please call Member Services for information. It may take up to two months for EFT deductions to begin after signing up for EFT. Please continue to pay your monthly plan premium directly to Tufts Medicare Preferred until we notify you that you are enrolled in the EFT program.

Option 3: Paying Online

You can pay your monthly plan premium online by signing up for a secure personal account on our website at www.thpmp.org/registration. (If you already have an account, just go to www.thpmp.org/login.) In your personal account, you can see your current plan premium amount, what you paid the previous month, and how much is due next month. You can make a one-time payment of the amount due (your premium is due each month) or set up a recurring payment to be automatically deducted from your bank account each month. For more details on how to sign up for a secure personal account, call Member Services or go to www.thpmp.org/registration.

Option 4: Having your premium taken out of your monthly Social Security check

Changing the way you pay your plan premium

If you decide to change the option by which you pay your plan premium, it can take up to three months for your new payment method to take effect. While we are processing your request for a new payment method, you are responsible for making sure that your plan premium is paid on time. To change your payment method, contact Member Services.

What to do if you are having trouble paying your plan premium

Your plan premium is due in our office by the 15th of each month. If we have not received your premium by the 15th, we will send you a notice telling you that your plan membership will end if we do not receive your premium payment within 2 months.

If you are having trouble paying your premium on time, please contact Member Services to see if we can direct you to programs that will help with your costs.

If we end your membership because you did not pay your premiums, you will have health coverage under Original Medicare. At the time we end your membership, you may still owe us for premiums you have not paid. We have the right to pursue collection of the amount you owe. In the future, if you want to enroll again in our plan (or another plan that we offer), you will need to pay the amount you owe before you can enroll.

If you think we have wrongfully ended your membership, you can make a complaint (also called a grievance); see Chapter 7 for how to file a complaint. If you had an emergency circumstance that was out of your control and it caused you to not be able to pay your premiums within our grace period, you can make a complaint. For complaints, we will review our decision again. Chapter 7, Section 9 of this document tells how to make a complaint, or you can call us at 1-800-701-9000, 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31 and Monday – Friday from April 1 to September 30. TTY users should call 711. You must make your request no later than 60 calendar days after the date your membership ends.

Section 5.2 Can we change your monthly plan premium during the year?

No. We are not allowed to change the amount we charge for the plan's 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 6 Keeping your plan membership record up to date

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 Provider/Medical Group/IPA.

The doctors, hospitals, 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 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 or domestic partner's employer, workers' compensation, or 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 (**Note:** You are not required to tell your plan about the clinical research studies you intend to participate in but we encourage you to do so.)

If any of this information changes, please let us know by calling Member Services. Members with a personal online account are able to update certain information on our website. For details on how to sign up for a secure personal account, call Member Services or go to www.thpmp.org/registration.

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.

SECTION 7 How other insurance works with our plan

Other insurance

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. This is called **Coordination of Benefits**.

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 Member Services. 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.

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. If you have other insurance, tell your doctor, hospital, and pharmacy.

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 group health 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 or domestic partner is still working, your group health 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

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

CHAPTER 2:

*Important phone numbers and
resources*

SECTION 1 Tufts Medicare Preferred HMO Basic No Rx contacts (how to contact us, including how to reach Member Services)

How to contact our plan's Member Services

For assistance with claims, billing, or member card questions, please call or write to Tufts Medicare Preferred HMO Basic No Rx Member Services. We will be happy to help you.

Method	Member Services – Contact Information
CALL	<p>1-800-701-9000 Calls to this number are free.</p> <p>Representatives are available 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31 and Monday – Friday from April 1 to September 30. After hours and on holidays, please leave a message and a representative will return your call on the next business day.</p> <p>Member Services also has free language interpreter services available for non-English speakers.</p>
TTY	<p>711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.</p> <p>Representatives are available 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31 and Monday – Friday from April 1 to September 30. After hours and on holidays, please leave a message and a representative will return your call on the next business day.</p>
FAX	1-617-972-9405
WRITE	<p>Tufts Medicare Preferred Attn: Member Services P.O. Box 494 Canton, MA 02021</p>
WEBSITE	www.thpmp.org

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

Method	Coverage Decisions for Medical Care – Contact Information
CALL	<p>1-800-701-9000 Calls to this number are free.</p> <p>Representatives are available 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31 and Monday – Friday from April 1 to September 30. After hours and on holidays, please leave a message and a representative will return your call on the next business day.</p> <p>Member Services also has free language interpreter services available for non-English speakers.</p>
TTY	<p>711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.</p> <p>Representatives are available 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31 and Monday – Friday from April 1 to September 30. After hours and on holidays, please leave a message and a representative will return your call on the next business day.</p>
FAX	1-617-972-9405
WRITE	<p>Tufts Medicare Preferred Attn: Member Services P.O. Box 494 Canton, MA 02021</p>
WEBSITE	www.thpmp.org

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

Method	Appeals for Medical Care – Contact Information
CALL	<p>1-800-701-9000 Calls to this number are free.</p> <p>Representatives are available 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31 and Monday – Friday from April 1 to September 30. After hours and on holidays, please leave a message and a representative will return your call on the next business day.</p> <p>Member Services also has free language interpreter services available for non-English speakers.</p>
TTY	<p>711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.</p> <p>Representatives are available 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31 and Monday – Friday from April 1 to September 30. After hours and on holidays, please leave a message and a representative will return your call on the next business day.</p>
FAX	1-617-972-9516
WRITE	<p>Tufts Medicare Preferred Attn: Appeals & Grievances P.O. Box 474 Canton, MA 02021</p>
WEBSITE	www.thpmp.org

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. For more information on making a complaint about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Complaints about Medical Care – Contact Information
CALL	<p>1-800-701-9000 Calls to this number are free.</p> <p>Representatives are available 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31 and Monday – Friday from April 1 to September 30. After hours and on holidays, please leave a message and a representative will return your call on the next business day.</p> <p>Member Services also has free language interpreter services available for non-English speakers.</p>
TTY	<p>711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.</p> <p>Representatives are available 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31 and Monday – Friday from April 1 to September 30. After hours and on holidays, please leave a message and a representative will return your call on the next business day.</p>
FAX	1-617-972-9516
WRITE	<p>Tufts Medicare Preferred Attn: Appeals & Grievances P.O. Box 474 Canton, MA 02021</p>
MEDICARE WEBSITE	<p>You can submit a complaint about Tufts Medicare Preferred HMO Basic No Rx directly to Medicare. To submit an online complaint to Medicare go to www.medicare.gov/MedicareComplaintForm/home.aspx.</p>

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

If you have received a bill or paid for services (such as a provider bill) that you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. See Chapter 5 (*Asking us to pay our share of a bill you have received for covered medical services*).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) for more information.

Method	Payment Request – Contact Information
CALL	<p>1-800-701-9000 Calls to this number are free.</p> <p>Representatives are available 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31 and Monday – Friday from April 1 to September 30. After hours and on holidays, please leave a message and a representative will return your call on the next business day.</p> <p>Member Services also has free language interpreter services available for non-English speakers.</p>
TTY	<p>711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.</p> <p>Representatives are available 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31 and Monday – Friday from April 1 to September 30. After hours and on holidays, please leave a message and a representative will return your call on the next business day.</p>
FAX	1-617-972-1028
WRITE	Tufts Medicare Preferred P.O. Box 518 Canton, MA 02021
WEBSITE	www.thpmp.org

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	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	www.Medicare.gov 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 documents you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: <ul style="list-style-type: none">• Medicare Eligibility Tool: Provides Medicare eligibility status information.

Method	Medicare – Contact Information
WEBSITE (CONTINUED)	<ul style="list-style-type: none">• 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. <p>You can also use the website to tell Medicare about any complaints you have about Tufts Medicare Preferred HMO Basic No Rx:</p> <ul style="list-style-type: none">• Tell Medicare about your complaint: You can submit a complaint about Tufts Medicare Preferred HMO Basic No Rx 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 and review the information with 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 the Health Insurance Needs of Everyone).

SHINE is an independent (not connected with any insurance company or health plan) 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 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 with Medicare questions or problems and help you understand your Medicare plan choices and answer questions about switching plans.

METHOD TO ACCESS SHIP and OTHER RESOURCES:

- Visit <https://www.shiphelp.org> (Click on SHIP LOCATOR in middle of page)
- Select your **STATE** from the list. This will take you to a page with phone numbers and resources specific to your state.

Method	SHINE (Serving the Health Insurance Needs of Everyone) (Massachusetts' SHIP) – Contact Information
CALL	1-800-243-4636
TTY	1-800-439-2370 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/health-insurance-counseling

SECTION 4 Quality Improvement Organization

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For Massachusetts, the Quality Improvement Organization is called Acentra Health.

Acentra Health has a group of doctors and other health care professionals who are paid by Medicare to check on and help improve the quality of care for people with Medicare. Acentra Health is an independent organization. It is not connected with our plan.

You should contact Acentra Health 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	Acentra Health (Massachusetts' Quality Improvement Organization) – Contact Information
CALL	1-888-319-8452 Monday - Friday: 9:00 a.m. - 5:00 p.m. Weekends - Holidays: 11:00 a.m. - 3:00 p.m. 24-hour voicemail service is available. Translation services are available for beneficiaries and caregivers who do not speak English.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Acentra Health BFCC-QIO Program 5201 West Kennedy Blvd Suite 900 Tampa, FL 33609
WEBSITE	www.acentraqio.com

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents 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. To apply for Medicare, you can call Social Security or visit your local Social Security office.

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 8:00 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 Calls to this number are free. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Available 8:00 am to 7:00 pm, Monday through Friday.
WEBSITE	www.ssa.gov

SECTION 6 Medicaid

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 Medicaid. The programs offered through Medicaid help people with Medicare pay their Medicare costs, such as their Medicare premiums. These **Medicare Savings Programs** include:

- **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 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.

To find out more about Medicaid and its programs, contact MassHealth.

Method	MassHealth (Massachusetts' Medicaid Program) – Contact Information
CALL	1-800-841-2900 Hours: Self-service available 24 hrs/day in English and Spanish. Other services available Mon-Fri 8:00 a.m. – 5:00 p.m. Interpreter service available. The MassHealth Enrollment Center (MEC) hours are Mon-Fri 8:00 a.m. – 5:00 p.m.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	MassHealth Central Office 100 Hancock Street, 1st Floor Quincy, MA 02171
WEBSITE	www.mass.gov/topics/masshealth

SECTION 7 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 receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

Method	Railroad Retirement Board – Contact Information
CALL	1-877-772-5772 Calls to this number are free. If you press “0”, you may speak with an RRB representative from 9:00 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9:00 am to 12:00 pm on Wednesday. If you press “1”, you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.

Method	Railroad Retirement Board – Contact Information
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	rrb.gov/

SECTION 8 Do you have group insurance or other health insurance from an employer?

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner's) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Member Services if you have any questions. You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Member Services are printed on the back cover of this document.) You may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan.

CHAPTER 3:

*Using the plan for your medical
services*

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

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

For the details on what medical care is covered by our plan and how much you pay when you get this care, use the benefits chart in the next chapter, Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*).

Section 1.1 What are network providers and covered services?

- **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 and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their 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 covered by the plan

As a Medicare health plan, Tufts Medicare Preferred HMO Basic No Rx must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

Tufts Medicare Preferred HMO Basic No Rx will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this document).
- **The care you receive is considered medically necessary.** Medically necessary means that the services, supplies, equipment, 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 provider (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 services. 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. This means that you will have to pay the provider in full for the services furnished. *Here are three exceptions:*
 - The plan covers emergency or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.
 - If you need medical care that Medicare requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost sharing you normally pay in-network. Prior authorization from the plan may be required before you receive care out of network. In this situation, you will pay the same as you would pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.
 - The plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay the plan for dialysis can never exceed the cost sharing in Original Medicare. If you are outside the plan's service area and obtain the dialysis from a provider that is outside the plan's network, your cost sharing cannot exceed the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to obtain services inside the service area from a provider outside the plan's network the cost sharing for the dialysis may be higher.

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

<h3>Section 2.1 You must choose a Primary Care Provider (PCP) to provide and oversee your medical care</h3>

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

When you become a member of our plan, you must choose a plan provider to be your PCP. Your PCP is a physician, nurse practitioner, or physician's assistant who meets state requirements and is trained to give you general medical care. As we explain below, you will get your routine or general medical care from your PCP. Your PCP will also coordinate referrals to other network providers such as specialists.

What types of providers may act as a PCP?

Generally, Internal Medicine, General Medicine, Geriatrician, or Family Practitioners act as PCPs. A nurse practitioner or physician's assistant may also be a PCP.

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 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 MassRelay at TTY (English) 1-800-439-2370 or TTY (Spanish) 1-866-930-9252 for assistance contacting your PCP after hours (the non-TTY number for MassRelay 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 Medicare Preferred physicians are included in your PCP's referral circle. This means that in most cases, you will not have access to the entire Tufts Medicare Preferred 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, services, equipment, and supplies require authorization from Tufts Medicare Preferred 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 contracted provider is responsible for obtaining this authorization. Please be sure to check with your PCP or other contracted 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*. Using the Doctor Search tool on our website provides the most up-to-date information. Once you have made a choice, you should call Member Services (see the number on the back of this document). A Member Services representative will verify that the PCP you have chosen is accepting new patients. If you are to be admitted to a particular hospital or see a particular plan specialist, check the *Provider Directory*, or speak with a Member Services representative to be sure your PCP of choice uses that hospital or makes referrals to that specialist.

Please note: If your current PCP is a Tufts Medicare Preferred HMO contracted provider, you should check to see which hospital s/he uses for Tufts Medicare Preferred HMO members. Although your PCP may have admitting privileges at a number of hospitals, s/he may use one particular hospital for Tufts Medicare Preferred HMO members, and it may be a different hospital from one you have been referred to in the past.

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.

If you change your PCP, the specialists and hospitals your new PCP refers you to may be different than the specialists and hospitals your previous PCP referred you to. In other words, your new PCP may have a different referral circle. See Section 2.3 for more information about referral circles.

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.

To change your PCP, call Member Services. When you call, be sure to tell Member Services if you are seeing specialists or getting other covered services that needed your PCP's approval (such as durable medical equipment). Member Services will help make sure that you can

continue with the specialty care and other services you have been getting when you change your PCP. They will also check that the PCP you want to switch to is accepting new patients. If the PCP is accepting new patients, you will be able to make an appointment with your new PCP beginning the first of the following month. Member Services 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 of your new PCP. We suggest that you make an appointment with, and arrange for your records to be transferred to, your new PCP.

Members with a personal online account are able to change their PCP on our website and select a new PCP within our network. For details on how to sign up for a secure personal online account call Member Services (see the number on the back of this document) or go to www.thmp.org/registration.

Section 2.2 What kinds of medical care can you get without a referral from your PCP?

You can get the services 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 (or vaccines), COVID-19 vaccinations, 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 plan-covered services, which are services requiring immediate medical attention that are not emergencies, provided you are temporarily outside the service area of the plan, or it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts. Examples of urgently needed services are unforeseen medical illnesses and injuries or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable.
- 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 Member Services before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away.
- 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. Your PCP may require an office visit before issuing a referral to a specialist.

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

Certain drugs, services, equipment, and supplies require authorization from Tufts Medicare Preferred 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 contracted provider is responsible for obtaining this authorization. Please be sure to check with your PCP or other contracted 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. You can also call Member Services at the number on the back of this document for a list of services requiring your PCP or other contracted provider to obtain prior authorizations from the plan. Please refer to your Tufts Medicare Preferred HMO Formulary for drugs that require prior authorization.

What is a “referral circle”?

Each plan PCP has certain plan specialists called a *referral circle* that s/he uses for providing medical care to you.

This means that in most cases, you will not have access to the entire Tufts Medicare Preferred 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 in ***bold italics*** 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?

It is important that you know that we may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. If your doctor or specialist leaves your plan, you have certain rights and protections 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.
- We will notify you that your provider is leaving our plan so that you have time to select a new provider.
 - If your primary care or behavioral health providers leave our plan, we will notify you if you have seen that provider within the past three years.
 - If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.
- We will assist you in selecting a new qualified in-network provider that you may access for continued care.
- If you are currently undergoing medical treatment or therapies with your current provider, you have the right to request, and we will work with you to ensure, that the medically necessary treatment or therapies you are receiving continues.
- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.
- We will arrange for any medically necessary covered benefit outside of our provider network, but at in-network cost sharing, when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. Prior authorization from the plan may be required before you receive care out of network.
- 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 to manage your care.
- 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 a quality of care complaint to the QIO, a quality of care grievance to the plan, or both. Please see Chapter 7.

Section 2.4 How to get care from out-of-network providers

Seeing an out-of-network provider requires a referral from your PCP or network provider. If you are unable to obtain that referral, you or your authorized representative may also submit a request to Tufts Medicare Preferred for an “organization determination”. Authorization from Tufts Medicare Preferred 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 Medicare Preferred. See Chapter 4 for more information.

Under limited circumstances, our plan will allow our members to see out-of-network providers. These circumstances include seeing a provider with a specialty not currently contracted with our plan. We have contracted with providers across our service area to ensure access to care for our members. You must get a referral from your network provider and receive prior authorization from the plan prior to receiving care out-of-network.

Other circumstances when our plan will cover out-of-network services without referral or prior authorization include:

- The plan covers emergency care or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 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 and are not able to access contracted ESRD providers.

If you need medical care that Medicare requires our plan to cover and the providers in our network cannot provide that medical care, you can get this care from an out-of-network provider and/or facility. However, authorization must be obtained from the Plan prior to seeking care. In this situation, if the service is approved, you will pay the same as you would pay if you got the care from a network provider. You, your doctor, or your representative may call, write or fax our plan to make a request for authorization. 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 asking for a coverage decision about your medical care*.

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

Section 3.1 Getting care if you have a medical emergency

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 (and, if you are a pregnant woman, loss of an unborn child), loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. 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. You do not need to use a network doctor. You may get covered emergency medical care throughout the world, and from any provider with an appropriate state license even if they are not part of our network. Our plan covers worldwide emergency and urgent care services outside the United States when medically necessary. Please see Chapter 4 for more details.

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. The phone number to call our plan is on the back of your membership card.

What is covered if you have a medical emergency?

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency.

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 doctors will continue to treat you until your doctors contact us and make plans for additional care. 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 services* 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 services

What are urgently needed services?

A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service if either you are temporarily outside the service area of the plan, or it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable.

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 plan provider, you can go to any provider or clinic that provides urgently needed care, or you can dial 911 for immediate help.

Our plan covers worldwide emergency and urgent care services outside the United States when medically necessary.

Section 3.3 Getting care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from your plan.

Please visit the following website: www.medicare.gov/what-medicare-covers/getting-care-drugs-in-disasters-or-emergencies for information on how to obtain needed care during a disaster.

Generally, if you cannot use a network provider during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost-sharing.

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

Section 4.1 You can ask us to pay our share of the cost of covered services

If you have paid more than your plan cost sharing for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 5 (*Asking us to pay our share of a bill you have received for covered medical services*) for information about what to do.

Section 4.2 If services are not covered by our plan, you must pay the full cost

Tufts Medicare Preferred HMO Basic No Rx covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4 of this document. If you receive services not covered by our plan or services obtained out-of-network and that were not authorized, you are responsible for paying the full cost of services.

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. Paying for costs once a benefit limit has been reached will not apply toward the out-of-pocket maximum. You can call Member Services 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?

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. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically request volunteers to participate in the study.

Once Medicare approves the study, and you express interest, 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. If you tell us that you are in a qualified clinical trial, then you are only responsible for the in-network cost sharing for the services in that trial. If you paid more (for example, if you already paid the Original Medicare cost sharing amount), we will reimburse the difference between what you paid and the in-network cost sharing. However, you will need to provide documentation to show us how much you paid. 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 any Medicare-approved clinical research study, you do *not* need to tell us or 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. Please note that this does not include benefits for which our plan is responsible that include, as a component, a clinical trial or registry to assess the benefit. These include certain benefits specified under national coverage determinations requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies and may be subject to prior authorization and other plan rules.

Although you do not need to get our plan's permission to be in a clinical research study, covered for Medicare Advantage enrollees by Original Medicare, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

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.*

Section 5.2 When you participate in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, Original Medicare covers the 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.

After Medicare has paid its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan. However, you are required to submit documentation showing how much cost sharing you paid. Please see Chapter 5 for more information for submitting requests for payments.

Here's an example of how the cost sharing works: Let's say that you have a lab test that costs \$100 as part of the research study. Let's also say that your share of the costs for this test is \$20 under Original Medicare, but the test would be \$10 under our plan's benefits. In this case, Original Medicare would pay \$80 for the test and you would pay the \$20 copay required under Original Medicare. You would then notify your plan that you received a qualified clinical trial service and submit documentation such as a provider bill to the plan. The plan would then directly pay you \$10. Therefore, your net payment is \$10, the same amount you would pay under our plan's benefits. Please note that in order to receive payment from your plan, you must submit documentation to your plan such as a provider bill.

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 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.
- Items and services customarily provided by the research sponsors free-of-charge for any enrollee in the trial.

Do you want to know more?

You can get more information about joining a clinical research study by visiting the Medicare website to read or download the publication *Medicare and Clinical Research Studies*. (The

publication is available at: www.medicare.gov/sites/default/files/2019-09/02226-medicare-and-clinical-research-studies.pdf.) 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 in a religious non-medical health care institution

Section 6.1 What is a religious non-medical health care institution?

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. 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. This benefit is provided only for Part A inpatient services (non-medical health care services).

Section 6.2 Receiving Care From a Religious Non-Medical Health Care Institution

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 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?

Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of Tufts Medicare Preferred HMO Basic No Rx, however, you usually will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan, even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under certain limited circumstances we will transfer ownership of the DME item to you. Call Member Services for more information.

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

If you did not acquire ownership of the DME item while in our plan, you will have to make 13 new consecutive payments after you switch to Original Medicare in order to own the item. The payments made while enrolled in your plan do not count.

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare do not count. You will have to make 13 payments to our plan before owning the item.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You were in our plan but did not obtain ownership while in our plan. You then go back to Original Medicare. You will have to make 13 consecutive new payments to own the item once you join Original Medicare again. All previous payments (whether to our plan or to Original Medicare) do not count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage, Tufts Medicare Preferred HMO Basic No Rx will cover:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related oxygen accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

If you leave Tufts Medicare Preferred HMO Basic No Rx or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

What happens if you leave your plan and return to Original Medicare?

Original Medicare requires an oxygen supplier to provide you services for five years. During the first 36 months you rent the equipment. The remaining 24 months the supplier provides the equipment and maintenance (you are still responsible for the copayment for oxygen). After five years you may choose to stay with the same company or go to another company. At this point, the five-year cycle begins again, even if you remain with the same company, requiring you to pay copayments for the first 36 months. If you join or leave our plan, the five-year cycle starts over.

CHAPTER 4:

*Medical Benefits Chart
(what is covered and what you
pay)*

SECTION 1 Understanding your out-of-pocket costs for covered services

This chapter provides a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of Tufts Medicare Preferred HMO Basic No Rx. 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 Types of out-of-pocket costs you may pay for your covered services

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services:

Copayment is a fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)

Coinsurance is a percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable.

Section 1.2 What is the most you will pay for covered medical services?

Because you are enrolled in a Medicare Advantage Plan, there is a limit on the total amount you have to pay out-of-pocket each year for in-network medical services that are covered by our plan. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. For calendar year 2025 this amount is \$3,650.

The amounts you pay for copayments and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. (The amount you pay for your plan premium does not count toward your maximum out-of-pocket amount.) In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart. If you reach the maximum out-of-pocket amount of \$3,650, you will not have to pay any out-of-pocket costs for the rest of the year for in-network covered services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Our plan does not allow providers to balance bill you

As a member of Tufts Medicare Preferred HMO Basic No Rx, an important protection for you is that you only have to pay your cost sharing amount when you get services covered by our plan. Providers may not add additional separate charges, called **balance billing**. This protection 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.

Here is how this protection works.

- If your cost-sharing is a copayment (a set amount of dollars, for example, \$15.00), then you pay only that amount for any covered services from a network provider.
- If your cost-sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
 - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
 - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral or for emergencies or urgently needed services.)
 - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral, or for emergencies or outside the service area for urgently needed services.)
- If you believe a provider has *balance billed* you, call Member Services.

SECTION 2 Use the *Medical Benefits Chart* to find out what is covered and how much you will pay

Section 2.1 Your medical benefits and costs as a member of the plan

The Medical Benefits Chart on the following pages lists the services Tufts Medicare Preferred HMO Basic No Rx covers and what you pay out of pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, equipment, and Part B prescription drugs) *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.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan may not require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered, unless it is emergent or urgent care or unless your plan or a network provider has given you a referral. This means that you will have to pay the provider in full for the services furnished.
- You have a primary care provider (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.
- Some of the services listed in the Medical 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 Medical Benefits Chart in ***bold italics***.
- If your coordinated care plan provides approval of a prior authorization request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, your medical history, and the treating provider's recommendation.

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2025* handbook. View it online at 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. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.
- If Medicare adds coverage for any services during 2025, either Medicare or our plan will cover those services.

Important Benefit Information for Enrollees with Chronic Conditions

- If you are diagnosed with the following chronic condition(s) identified below and meet certain criteria, you may be eligible for special supplemental benefits for the chronically ill.
 - Congestive heart failure (CHF)
 - Chronic obstructive pulmonary disease (COPD)
 - Diabetes
 - Dementia
 - End-stage renal disease (ESRD)
 - Stroke and related conditions
- Please go to the *Special Supplemental Benefits for the Chronically Ill* row in the below Medical Benefits Chart for further detail.
- Please contact us to find out exactly which benefits you may be eligible for.




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




Medical Benefits Chart



Services that are covered for you	What you must pay when you get these services
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: <ul style="list-style-type: none"> • lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, or infectious disease, etc.); • not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing.	You pay \$20 per visit for Medicare-covered acupuncture services for chronic low back pain. 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>Provider Requirements:</p> <p>Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act) may furnish acupuncture in accordance with applicable state requirements.</p> <p>Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:</p> <ul style="list-style-type: none"> • a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. <p>Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.</p> <p>Additional Acupuncture Benefits:</p> <p>The plan covers acupuncture services for chronic low back pain provided by other licensed acupuncturists that do not meet the Provider Requirements outlined above. Coverage is subject to the same 20-visit annual limit imposed by Medicare.</p>	<p>You pay \$20 per visit for acupuncture services by a licensed acupuncturist to treat chronic low back pain.</p> <p>Before you receive services from a licensed acupuncturist 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>Additional acupuncture services are eligible for reimbursement under your Wellness Allowance. See Wellness Allowance benefit description for full details.</p>	
<p>Ambulance services</p> <p>Covered ambulance services, whether for an emergency or non-emergency situation, 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 could endanger the person's health or if authorized by the plan. If the covered ambulance services are not for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.</p> <p>Ambulance services are covered worldwide.</p>	<p><i>Prior authorization may be required for non-emergency transportation.</i></p> <p>You pay \$325 per one-way trip for Medicare-covered ambulance services.</p> <p>According to Medicare guidelines, emergency and non-emergency ambulance services are covered based on medical necessity. If your condition qualifies for coverage, you will pay the copayment listed above.</p> <p>If your condition does not meet Medicare criteria and you utilize the ambulance service, you will then be responsible for the entire cost.</p> <p>If you have questions about coverage for ambulance services, please contact Member Services.</p>

Services that are covered for you	What you must pay when you get these services
	Wheelchair van (chair car) transportation is not covered by Medicare even if provided by an ambulance company.
<p>Non-ambulance transportation</p> <p>Our plan covers non-ambulance transportation (e.g., by chair car/wheelchair van or sedan) through the plan-approved vendor from a hospital to a skilled nursing facility (SNF) or to your home.</p>	<p>You pay \$0 for non-ambulance transportation from a hospital to a skilled nursing facility or to your home when ordered by the discharging hospital.</p>
<p>Annual physical exam</p> <p>The annual physical exam is 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. Covered once every calendar year.</p>	<p>You pay \$0 for an annual physical. If you receive services that address a medical condition during the same office visit, additional cost-share may apply.</p>
<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 calendar year.</p> <p>Note: Your first annual wellness visit can't take place within 12 months of your <i>Welcome to Medicare</i> preventive visit. However, you don't need to have had a <i>Welcome to Medicare</i> 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. If you receive services that address a medical condition during the same office visit, additional cost-share may apply.</p>

Services that are covered for you	What you must pay when you get these services
 Bone mass measurement 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.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.
 Breast cancer screening (mammograms) Covered services include: <ul style="list-style-type: none"> • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women aged 40 and older • Clinical breast exams once every 24 months 	There is no coinsurance, copayment, or deductible for covered screening mammograms and clinical breast exams.
Cardiac rehabilitation services 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><i>Except in an emergency, prior authorization may be required before you receive this service.</i></p> <p>You pay \$0 for Medicare-covered services.</p> <p>Before you receive services you must first obtain a referral from your PCP.</p>
 Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one 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	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy

Services that are covered for you	What you must pay when you get these services
your blood pressure, and give you tips to make sure you're eating healthy.	cardiovascular disease preventive benefit.
 Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.
 Cervical and vaginal cancer screening Covered services include: <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 or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months 	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services Covered services include: <ul style="list-style-type: none"> • Manual manipulation of the spine to correct subluxation Additional coverage provided by Tufts Medicare Preferred HMO Basic No Rx <ul style="list-style-type: none"> • Chiropractic initial evaluation covered once per calendar year 	<p><i>Except in an emergency, prior authorization may be required before you receive this service.</i></p> <p>You pay \$15 for each Medicare-covered visit.</p> <p>You pay \$15 for the initial chiropractic evaluation.</p> <p>Before you receive services you must first</p>

Services that are covered for you	What you must pay when you get these services
	<p>obtain a referral from your PCP.</p> <p>Other forms of chiropractic care are not covered benefits. See Chapter 4, Section 3.1 for services excluded from coverage.</p>
<p> Colorectal cancer screening</p> <p>The following screening tests are covered:</p> <ul style="list-style-type: none"> • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high-risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high-risk criteria. Once every 3 years. • Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. 	<p>There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam, including barium enemas. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam and you pay \$0 copayment for your doctor's services.</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none">• Barium Enema as an alternative to flexible sigmoidoscopy for patient not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. <p>Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.</p>	

Services that are covered for you	What you must pay when you get these services
<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. However, Medicare currently pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation.</p> <p>See below for information on supplemental dental coverage you get as a Tufts Medicare Preferred HMO Basic No Rx member.*</p>	<p><i>Except in an emergency, prior authorization may be required before you receive dental services.</i></p> <p>You pay \$40 per visit for Medicare-covered dental services.</p> <p>Before you receive services you must first obtain a referral from your PCP.</p> <p>See Inpatient Hospital Care and Outpatient Services/Surgery in this chart for cost-sharing you pay when services are received in a hospital or ambulatory surgical facility.</p>
<p>Tufts Medicare Preferred Dental Plan*</p> <p>Your plan automatically includes coverage for supplemental dental services not covered by Original Medicare, including Diagnostic, Preventive, and Basic dental services. There is an annual benefit maximum, and cost shares apply for these supplemental dental services, which are described below. The plan does <i>not</i> cover Major dental services such as oral surgery, periodontics, endodontics, and prosthodontics.</p> <p>The plan pays up to the Calendar Year Maximum of \$1,000 for all covered supplemental dental services. Services received from a dentist in an emergency situation are subject to plan rules and cost-sharing.</p>	<p>Cost-sharing information is provided below based on the class of dental services you receive.</p> <p>Refer to Section 2.2 of this chapter for the following additional important information:</p> <p>Pre-Treatment Estimates for explanation of how to</p>

* Cost-shares for these items/services do not count toward your annual maximum out-of-pocket amount.

Services that are covered for you	What you must pay when you get these services
<p>Supplemental dental services are covered with providers in the Dominion PPO Network only. To see if your dentist is a Dominion PPO Network dentist or if you need a new dentist, review the <i>Dental Directory</i> located at www.thpmp.org/dentist, or contact the Member Services number listed on the back cover of this document.</p> <p>You may further enhance your supplemental dental coverage by enrolling in the Tufts Medicare Preferred Dental <u>Option</u> for an additional premium. Refer to Section 2.2 of this chapter for a description of the supplemental dental benefit you get if you enroll in the Tufts Medicare Preferred Dental <u>Option</u>. If you enroll in the Tufts Medicare Preferred Dental <u>Option</u> it replaces the Tufts Medicare Preferred Dental <u>Plan</u> described in this section.</p> <p><u>Class 1 Diagnostic and Preventive Services</u></p> <p>Comprehensive Oral Exam (including the initial dental history and charting of teeth) covered once every 36 months.</p> <p>Periodic Oral Evaluation covered twice per year.</p>	<p>seek <i>Pre-Treatment Estimates</i> before receiving dental care.</p> <p>Limitations and Exclusions for <i>Limitations and Exclusions</i> that apply to both the Tufts Medicare Preferred Dental <u>Plan</u> (for no additional premium, described in this section) and the Tufts Medicare Preferred Dental <u>Option</u> (for an additional premium, described in Section 2.2 of this chapter).</p> <p>Note: If the Plan determines (1) a less expensive procedure, service, or course of treatment can be performed in place of your dentist's proposed treatment and (2) the less expensive alternative will produce a professionally satisfactory result, then the maximum allowed by the Plan will be the charge for the less expensive alternative.</p> <p>You pay \$0 for Class 1 Diagnostic and Preventive Services.</p>

Services that are covered for you	What you must pay when you get these services
<p>Intra oral bitewing X-rays images (X-rays of the crowns of the teeth) covered twice per year when oral conditions indicate need.</p> <p>Prophylaxis (routine cleaning, scaling and polishing of teeth) covered twice per year.</p> <p><u>Class 2 Basic Services</u></p> <p>Emergency oral evaluation problem focused exams covered once every 12 months.</p> <p>Intra oral X-ray image of the entire mouth (panoramic image) covered once every 60 months.</p> <p>Intra oral X-ray image of the entire mouth (full mouth series) covered once every 60 months.</p> <p>Single tooth X-ray images covered as needed.</p> <p>Silver fillings and white fillings covered once every 24 months per surface, per tooth.</p> <p>Periodontal cleaning covered once every 6 months following active periodontal therapy, not to be combined with regular cleanings.</p> <p>Scaling and root planing covered once every 24 months, per quadrant.</p> <p>Scaling in presence of generalized moderate/severe gingival inflammation covered once every 24 months after oral evaluation and in lieu of a covered prophylaxis.</p> <p>Full mouth debridement covered once per lifetime.</p> <p>Simple extractions covered once per tooth.</p> <p>Minor treatment for pain relief covered only if no services other than exam and X-rays were performed on the same date of service.</p>	<p>You pay 50% coinsurance for Class 2 Basic Services.</p>


Services that are covered for you	What you must pay when you get these services
 Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.
 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. You may be eligible for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test.	There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.
 Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: <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. 	<p><i>Except in an emergency, prior authorization may be required before you receive Continuous Glucose Monitors.</i></p> <p>You pay \$0 for covered services.</p> <p>If you are also treated or monitored for an existing medical condition during the visit when you receive services, additional cost-share will apply for the care received for the existing medical condition.</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • 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 • For persons at risk of diabetes: Fasting plasma glucose tests as medically necessary. • For foot care services related to diabetes, see Podiatry Services in this benefit chart. <p>Note: There are two kinds of Continuous Glucose Monitors (CGMs) - Adjunctive and Therapeutic. Both are covered in full by your plan. Adjunctive CGMs may only be purchased from participating medical equipment suppliers, or the CGMs' manufacturer when contracted directly with the plan.</p>	<p>Before you receive diabetes self-management training services you must first obtain a referral from your PCP.</p> <p>Coverage for blood glucose monitors and blood glucose test strips is limited to the OneTouch products manufactured by LifeScan, Inc. Please note, there is no preferred brand for lancets or glucose control solutions.</p> <p>Covered therapeutic Continuous Glucose Monitors (CGMs) include Dexcom and FreeStyle Libre products that are considered Durable Medical Equipment (DME) by Medicare. There is no preferred brand for adjunctive CGMs.</p> <p>Diabetic testing supplies, including test strips, lancets, glucose meters, and CGMs are also covered at participating retail or mail-order pharmacies.</p> <p>You must first obtain a prescription from your PCP or physician</p>

Services that are covered for you	What you must pay when you get these services
	treating your diabetes for covered diabetic supplies (including therapeutic custom-molded shoes).
<p>Durable medical equipment (DME) and related supplies</p> <p>(For a definition of “durable medical equipment”, see Chapter 10 of this document as well as Chapter 3, Section 7.)</p> <p>Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, PAP therapy and oxygen equipment, nebulizers, and walkers.</p> <p>We cover all medically necessary DME 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>Note:</p> <ul style="list-style-type: none"> For coverage, the item/supplies must be covered by the plan; medically necessary; provided by an in-network DME supplier; and in some instances, have a prior authorization on file. For help determining whether items/supplies are covered, and/or whether prior authorization is required, and/or whether a DME supplier is in our network, call Member Services. 	<p><i>Except in an emergency, prior authorization may be required before you obtain certain durable medical equipment and related supplies.</i></p> <p>You pay 20% coinsurance for covered items and related supplies.</p> <p>Qualification for each item is dependent on the listed criteria.</p> <p>Your cost-sharing for Medicare oxygen equipment coverage is 20% every month.</p> <p>After 36 months, you will stop paying the 20% coinsurance for your oxygen equipment, until the benefit resets at the five year mark. Once the benefit resets you will resume paying the applicable cost-share based on your plan’s current benefit design.</p> <p>If prior to enrolling in Tufts Medicare Preferred HMO Basic No Rx you</p>

Services that are covered for you	What you must pay when you get these services
<p>Additional items covered by Tufts Medicare Preferred: Bathroom Safety Equipment</p> <p>The following Bathroom Safety Equipment is covered for members who have a functional impairment when having the item will improve safety (installation not covered):</p> <ul style="list-style-type: none"> • Raised Toilet Seat: 1 per member every 5 years • Bathroom Grab Bars: Up to 2 per member every 5 years • Tub Seat: 1 per member every 5 years 	<p>had made 36 months of rental payments for oxygen equipment coverage, your cost-sharing in Tufts Medicare Preferred HMO Basic No Rx is 20%.</p> <p>Refer to the Diabetes self-management training, diabetic services and supplies section in this Medical Benefits Chart for coverage details of diabetic supplies.</p> <p>You pay 20% coinsurance for bathroom safety equipment upon written prescription from a network provider to a network DME or Orthotics and Prosthetics (O&P) supplier in your PCP's referral circle.</p> <p>Qualification for each item is dependent on the listed criteria.</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 	<p>You pay \$125 for each covered emergency room visit.</p> <p>If your visit to the emergency room also</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • 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 (and, if you are a pregnant woman, loss of an unborn child), 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>Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.</p> <p>Your plan includes worldwide coverage for emergency care.</p>	<p>includes outpatient hospital surgery performed in the emergency room as part of the emergency room visit to evaluate or stabilize your emergency medical condition, only your \$125 emergency care copayment applies.</p> <p>If your visit to the emergency room results in outpatient hospital surgery performed in an operating room, other hospital outpatient facility or ambulatory surgical center on the same date of service, the emergency care copayment is waived and your outpatient surgery copayment may apply. See Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers in this chart for more details.</p> <p>If you are held for observation following the emergency room visit, the emergency care copay will be waived and you will pay the Observation copay. See Outpatient hospital</p>

Services that are covered for you	What you must pay when you get these services
	<p>observation in this chart for more details including applicable copay.</p> <p>You do not pay this amount if you are admitted as an inpatient to the hospital within one day for the same condition (refer to Inpatient Hospital Care in this section for the hospital cost-share that applies instead).</p> <p>In some cases, you may have to pay an additional copayment for the services provided by certain providers in the emergency room.</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 and your cost is the cost-sharing you would pay at a network hospital.</p>
 Health and wellness education programs <u>Wellness Allowance</u>	<p>The plan reimburses you up to \$150 per calendar year toward eligible activities, items, and/</p>

Services that are covered for you	What you must pay when you get these services
<p>Our plan offers an annual Wellness Allowance to give you flexibility and choice while achieving and maintaining health and wellness. It is intended to supplement and complement your medical benefits. There is a maximum dollar amount for which you will be reimbursed each year. You may use your Wellness Allowance to cover the cost of any one – or any combination – of the following health-related items and services approved by the plan:</p> <ol style="list-style-type: none"> 1. Acupuncture visits not covered by your medical benefit (Must be provided by a licensed Acupuncturist.) 2. Evidence-based Health Education programs like those sponsored by your provider, the Healthy Living Center of Excellence (www.healthyliving4me.org), the Arthritis Foundation® (www.arthritis.org/health-wellness), and Triple-A (www.aaa.com). Other, specific examples include: <ul style="list-style-type: none"> • Chronic disease self-management programs • Driver improvement and/or safety programs • Healthy IDEAS (www.healthyideasprograms.org) • Powerful Tools for Caregivers (www.powerfultoolsforcaregivers.org) • EnhanceWellness (www.projectenhance.org/enhancewellness) 3. Nutritional Counseling not covered by your medical benefit to prevent or manage chronic conditions, achieve and maintain a healthy weight, and develop long-term healthy eating habits (Must be provided by a licensed nutrition professional or registered dietician.) 4. Fitness Benefit, which has three parts: <ul style="list-style-type: none"> • One fitness tracker or heart rate monitor per year (Includes smart watches, like the Apple Watch.) 	<p>or programs. You pay all charges over \$150 per calendar year. Sales tax is not eligible for reimbursement.</p> <p>Reimbursement requests must be received by Tufts Medicare Preferred, Inc. 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
<ul style="list-style-type: none"> • Memory fitness programs that exercise the brain to improve aspects of cognition like memory, attention, focus, and brain speed. Examples include Brain HQ and Vigorous Mind, a science-based, personalized desktop application for maintaining brain health, as well as smart-device applications like Elevate and Lumosity. • Physical fitness programs like instructor-led exercise classes, personal training sessions, and memberships at a gym or fitness center (Includes fitness studios, year-round pool facilities, health clubs, and community/senior centers. See descriptions below.) <ul style="list-style-type: none"> ✓ Gym – A fitness facility that focuses on training. Membership at a gym is for being coached. Gyms may offer large group, small group, semi-private one-on-one training, or any combination of the three. Gyms are smaller than fitness centers and do not have much cardiovascular equipment. ✓ Fitness center – A full-service health or fitness facility that includes cardiovascular and strength-training equipment plus amenities like showers, locker rooms, swimming pools, clinics, and courts. ✓ Fitness studio – Smaller than a fitness center, a fitness studio specializes in only one form of exercise like Barre, indoor cycling/spinning, CrossFit, boot camp, Pilates, yoga, tai chi, and qigong. The primary benefit of a fitness studio is that it does one type of fitness extremely well. ✓ Year-round pool facility – An indoor or indoor/outdoor aquatic center that can accommodate an array of water-based programs that facilitate the development of healthy lifestyles. Examples include swimming lessons, water aerobics or walking, and exercise lap swimming. 	

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> ✓ Health club – A high value/low price business model that allows you to pay one price to join and use cardiovascular and strength-training equipment but charges additional fees for instructor-led group classes, towels, and other amenities. ✓ Community/senior center – A centralized location where the members of a community can gather together for games, exercise, meals, and education. A senior center is a type of community center for older adults. <p>The physical fitness benefit includes reimbursement for home equipment like resistance bands, weights, stationary bicycles, treadmills, or fitness machines; online programs like Peloton; and smart-device applications like Fitbit Premium so members may exercise in the comfort and safety of their homes.</p> <p>5. The following Alternative Therapies:</p> <ul style="list-style-type: none"> • Holistic medicine practitioner visits that integrate conventional and alternative therapies to prevent and treat disease and, most importantly, promote optimal health. Holistic medicine includes the analysis of physical, nutritional, environmental, emotional, spiritual and lifestyle elements. It focuses on patient education and participation in the healing process. Coverage is for practitioner visits only. • Bodywork, which promotes awareness of the “body-mind connection” thereby affecting overall wellness, balance, and health. Most types of bodywork share goals such as pain relief, improved physical function, more freedom of movement, and heightened body awareness. Examples of bodywork include Shiatsu, Reflexology, and Reiki. 	

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • Mind-body therapies, which focus on the interactions among the brain, mind, body, and behavior, with the intent to use the mind to affect physical function and promote health. Many mind-body therapies invoke the relaxation response to help members stay healthy, reduce the severity or frequency of symptoms, and/or recover more rapidly from illness. Examples of mind-body therapies include Biofeedback, Imagery, and Breathwork. <p>Only therapies with practitioners licensed in the state where they provide services are covered. The benefit also includes reimbursement for home equipment, online programs, and smart-device applications so members may pursue Alternative Therapies at home. Examples of home equipment include guided video or audio recordings; self-massaging devices like foam rollers/sticks or TheraCane®; biofeedback machines for home use, like RESPeRATE®; and portable infrared saunas. These examples are specific to bodywork and mind-body therapies, as there is no home equipment for holistic medicine practitioner visits. Consumable (i.e., edible) products are excluded from the Alternative Therapies benefit.</p> <p>6. Therapeutic massage – Massage is the manual manipulation of superficial and deeper layers of muscle and connective tissue, using a variety of techniques, to enhance function, aid in the healing process, decrease muscle reflex activity, inhibit motor-neuron excitability, and promote relaxation and well-being. Massage is a hands-on form of healing work. Examples of therapeutic massage include Swedish, Deep Tissue, Sports, and Chair.</p> <p>To obtain this reimbursement please submit a Wellness Allowance reimbursement form along with proof of payment and any additional information outlined on the form. Proof of payment must be in the member's name or, alternatively, in the name of the member's representative on record. Call Member Services to request a reimbursement form or go to our website www.thpmp.org. Send the completed form with any required</p>	

Services that are covered for you	What you must pay when you get these services
<p>documents to the address shown on the form. If you have any questions, contact Member Services.</p> <p><u>SilverSneakers® Fitness</u></p> <p>(available to Tufts Medicare Preferred HMO Basic No Rx members who live in Worcester County only)</p> <p>SilverSneakers can help you live a healthier, more active life through fitness and social connection. As a Tufts Medicare Preferred member you are covered for a fitness benefit through SilverSneakers at participating locations,¹ where you can take classes² and use exercise equipment and other amenities, at no additional cost to you. Enroll in as many locations as you like, at any time.</p> <p>You also have access to instructors who lead specially designed group exercise online classes, seven days a week with SilverSneakers LIVE. Additionally, SilverSneakers Community gives you options to get active outside of traditional gyms at recreation centers, parks and other neighborhood locations. SilverSneakers also connects you to a support network and online resources through SilverSneakers On-Demand videos and the SilverSneakers GO mobile app. You also get access to Burnalong® with a supportive virtual community and thousands of classes for all interests and abilities.</p> <p>For members who prefer to exercise at home, SilverSneakers At-Home Kits are a good way to get started on your fitness journey. Whether you're not sure where to start or just not ready for the "gym" experience, ease into exercising with a SilverSneakers At-Home Kit. Members who choose SilverSneakers At-Home Kits may have one of the following exercise kits sent to them:</p> <ul style="list-style-type: none"> • Walking, which includes a pedometer; 	<p>You pay \$0 for this program (applies to Tufts Medicare Preferred HMO Basic No Rx members who live in Worcester County only).</p>

¹ Participating Locations ("PLs") are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL.

² Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location.


Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • Strength, which includes resistance tubing; • Toning, which includes an exercise ball; or • Yoga, which includes a yoga strap. <p>Each at-home exercise kit also comes with a Quick Start Guide.</p> <p>Visit www.tuftsmedicarepreferred.org and search “SilverSneakers” for more information or to get started. To find SilverSneakers fitness locations and Community classes, members can visit SilverSneakers.com or call 1-888-423-4632 (TTY: 711) Monday through Friday, 8 a.m. to 8 p.m. EST.</p> <p>Always talk with your doctor before starting an exercise program.</p> <p><u>Weight Management Programs</u></p> <p>The plan will cover program fees for weight loss programs such as WeightWatchers, 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 this reimbursement, please submit a Weight Management reimbursement form along with proof of payment and any additional information outlined on the form. Proof of payment must be in the member’s name or, alternatively, in the name of the member’s representative on record. Call Member Services to request a reimbursement form or go to our website www.thpmp.org. Send the completed form with any required documents to the address shown on the form. If you have any questions, contact Member Services.</p>	<p>The plan will reimburse members up to a maximum of \$150 per calendar year towards program fees for weight loss programs.</p> <p>Reimbursement requests must be received by Tufts Medicare Preferred by no later than March 31st of the following year.</p> <p>The Weight Management Programs Allowance and the Wellness Allowance are separate allowances.</p>
<p>Hearing services</p> <p>Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered</p>	

Services that are covered for you	What you must pay when you get these services
<p>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. A routine hearing test is a simple “pass” or “fail” test. Its purpose is to determine if you have normal hearing or not. If you have known decreased hearing or other hearing problems such as tinnitus, the exam would be considered a diagnostic exam and the diagnostic hearing exam copay will apply. Hearing Aid Fitting* 	<p>You pay \$40 for a Medicare-covered diagnostic hearing exam.</p> <p>You pay \$0 for an annual routine hearing test.</p> <p>No referral is required for an annual routine hearing test, but you must use a plan provider.</p> <p>Hearing aid fitting evaluations received through Hearing Care Solutions are \$0. If diagnostic tests are performed, additional cost-shares may apply.</p>

* Cost-shares for these items/services do not count toward your annual maximum out-of-pocket amount.


Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> Hearing Aids* <p>Note:</p> <ul style="list-style-type: none"> Hearing Care Solutions (HCS) is an in-network hearing aid provider that can be contacted at 1-866-344-7756. The hearing aid formulary mentioned in the right hand column is available through HCS at the number listed above. Hearing aids not listed on the HCS formulary are not covered. 	<p>You are eligible for up to 2 covered hearing aids per year (1 hearing aid per ear) through Hearing Care Solutions.</p> <p>To be covered, the hearing aids must be on the Hearing Care Solutions formulary and must be purchased through Hearing Care Solutions.</p> <p>You pay a copayment for each covered hearing aid, and the copayment amount depends on the type of hearing aid purchased through the Hearing Care Solutions formulary.</p> <p>\$250 copay for Standard level hearing aid.</p> <p>\$475 copay for Superior level hearing aid.</p> <p>\$650 copay for Advanced level hearing aid.</p> <p>\$850 copay for Advanced Plus level hearing aid.</p> <p>\$1,150 copay for Premier level hearing aid.</p>

* Cost-shares for these items/services do not count toward your annual maximum out-of-pocket amount.

Services that are covered for you	What you must pay when you get these services
<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 members eligible for Medicare-covered preventive HIV screening.</p>
<p>Home health agency care</p> <p>Prior to receiving home health services, a doctor must certify that you need home health services and will 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 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies 	<p><i>Except in an emergency, prior authorization may be required before you receive this service.</i></p> <p>You pay \$0 for Medicare-covered home health care 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>Home infusion therapy</p> <p>Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters).</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier 	<p><i>Except in an emergency, prior authorization may be required before you receive this service.</i></p> <p>You pay \$0 for Medicare-covered home infusion therapy services.</p> <p>The 2025 <i>Pharmacy Directory</i> lists home infusion providers in our network. An updated <i>Pharmacy Directory</i> is located on our website at www.thpmp.org. You may also call Member Services for updated provider information or to ask us to mail you a <i>Pharmacy Directory</i>.</p>
<p>Hospice care</p> <p>You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Drugs for symptom control and pain relief 	<p>When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Tufts Medicare Preferred HMO Basic No Rx.</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • Short-term respite care • Home care <p>When you are admitted to a hospice you have the right to remain in your plan; if you chose to remain in your plan you must continue to pay plan premiums.</p> <p><u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis:</u> Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost sharing.</p> <p><u>For services that are covered by Medicare Part A or B and are not related to your terminal prognosis:</u> 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 prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (such as if there is a requirement to obtain prior authorization).</p> <ul style="list-style-type: none"> • If you obtain the covered services from a network provider and follow plan rules for obtaining service, 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) <p><u>For services that are covered by Tufts Medicare Preferred HMO Basic No Rx but are not covered by Medicare Part A or B:</u> Tufts Medicare Preferred HMO Basic No Rx 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 prognosis. You pay your plan cost-sharing amount for these services.</p>	

Services that are covered for you	What you must pay when you get these services
<p>Note: If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.</p> <p>Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.</p>	
<p> Immunizations</p> <p>Covered Medicare Part B services include:</p> <ul style="list-style-type: none"> • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you are at risk and they meet Medicare Part B coverage rules 	<p>There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, hepatitis B, COVID-19 vaccines, and other vaccines if you are at risk and they meet Medicare Part B coverage rules.</p> <p>Medicare Part B cost share applies for other vaccines that meet Medicare Part B coverage rules. See the Medicare Part B prescription drugs section in this Medical Benefits Chart for applicable cost shares.</p>
<p>In-home Safety Assessment</p> <p>Additional service covered by Tufts Medicare Preferred</p> <p>The in-home safety assessment is performed when recommended by the member's PCP or Case Manager. This assessment is for members who do not qualify for Original Medicare's in-home safety assessment. The in-home safety</p>	<p>You pay \$0 for an in-home safety assessment.</p> <p>No referral is required for this service, but you must obtain the in-home safety</p>



Services that are covered for you	What you must pay when you get these services
<p>assessment includes evaluating a member's risk for a fall by evaluating:</p> <ol style="list-style-type: none"> 1. The Get up and Go test 2. Review of medications 3. A detailed history of falls, balance problems or incontinence 4. An evaluation of whether pain or joint problems may contribute to fall risk 5. A vision screening and hearing screening 6. Assessment of common rooms in the house (living room, kitchen, bedroom and bathroom) for environmental risks (throw rugs, cords, lighting, handrails) 	<p>assessment from a plan provider.</p>
<p>Inpatient hospital care</p> <p>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals 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><i>Except in an emergency, prior authorization may be required before you receive this service.</i></p> <p><u>Inpatient hospital care</u></p> <p>Each time you are admitted to an acute care hospital, you pay \$275 per day for days 1-5 and \$0 after day 5. A separate copay will not apply if during your admission you need a higher level of care that requires a transfer to another in-network acute care hospital for the purpose of continuing your care, with or without a return to the original admitting acute care hospital for additional care prior to discharge. A transfer from another facility such as an acute rehabilitation</p>

Services that are covered for you	What you must pay when you get these services
<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 • 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 use disorder services 	<p>or skilled nursing facility counts as a separate admission and will require a separate copay of \$275 per day for days 1-5 and \$0 after day 5 in the acute care hospital.</p> <p><u>Acute rehabilitation services</u></p> <p>Each time you are admitted to an acute rehabilitation or long-term acute care hospital, you pay \$275 per day for days 1-5 and \$0 after day 5 for up to 90 days in a benefit period for Medicare-covered services received in an acute rehabilitation or long-term acute care hospital. A separate copay will not apply if during your admission you need a higher level of care that requires a transfer to another in-network acute rehabilitation or long-term acute care hospital for the purpose of continuing your care, with or without a return to the original admitting acute rehabilitation or long-term acute care hospital for additional care prior to discharge.</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • 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 our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If Tufts Medicare Preferred HMO Basic No Rx provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. Usually transplants are only covered in our service area. • Blood – including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. • Physician services <p>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 <i>outpatient</i>. If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called <i>Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!</i> This fact sheet is available on the Web at https://es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.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>A transfer from another facility such as an acute care hospital or skilled nursing facility counts as a separate admission and will require a separate copay of \$275 per day for days 1-5 and \$0 after day 5 for up to 90 days in the acute rehabilitation or long-term acute care hospital.</p> <p>A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.</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
<p>Inpatient services in a psychiatric hospital</p> <p>Covered services include mental health care services that require a hospital stay.</p> <p>There is a 190-day lifetime limit for mental health care and substance use disorder services provided in a freestanding psychiatric hospital. The benefit is limited by prior partial or complete use of a 190-day lifetime treatment in a psychiatric hospital. The 190-day limit does not apply to mental health and substance use disorder services provided in a psychiatric unit of a general hospital.</p> <p>For inpatient mental health/substance use disorder services, you will be required to use the hospital within your primary care provider's (PCP's) referral circle designated for mental health services.</p> <p>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>	<p>Each time you are admitted to a psychiatric hospital for covered services, you pay \$275 per day for days 1-5 and \$0 after day 5. You have a maximum inpatient mental health benefit of 190 days per lifetime.</p> <p>You pay \$275 per day for days 1-5 and \$0 after day 5 for each mental health and/or substance use disorder stay in a general hospital.</p> <p>The 190-day lifetime limit does not apply to stays in a general acute care hospital.</p>
<p>Inpatient stay: Covered services received in a hospital or SNF 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 	<p>You pay \$0 for Medicare-covered services provided in the hospital or skilled nursing facility (SNF).</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • 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>Meals Post-Hospitalization/Rehabilitation</p> <p>After a qualifying discharge from hospital or extended care facility (including SNF, AIR, and LTACH), eligible members can receive up to 28 home-delivered meals (2 meals per day for 14 days). There is no annual limit to the number of discharges after which meals may be provided.</p> <p>Other conditions:</p> <ul style="list-style-type: none"> • Inpatient stay duration must be greater than two days. Observation and emergency room discharges regardless of length of stay are not eligible for this benefit. • Meal delivery service must be started within 30 days from date of discharge. • Members will be referred by a Care Manager to the plan approved vendor for meal delivery. <p>Call Member Services if you have questions about this benefit or would like to be referred to a Care Manager who will assess your eligibility and refer you to the plan approved vendor.</p>	<p>You pay \$0.</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>We also cover additional 3 hours of one-on-one counseling services each year for people who have exhausted their Medicare-covered benefit described above. A physician’s order is required for these additional, hourly sessions.</p>	<p>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.</p> <p>You pay \$0 for each additional, hourly session of one-on-one medical nutrition therapy services.</p>
<p> Medicare Diabetes Prevention Program (MDPP)</p> <p>MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans.</p> <p>MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.</p>	<p>There is no coinsurance, copayment, or deductible for the MDPP benefit.</p>

Services that are covered for you	What you must pay when you get these services
<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 • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • The Alzheimer's drug, Leqembi[®], (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment. • Clotting factors you give yourself by injection if you have hemophilia • Transplant/Immunosuppressive Drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Keep in mind, Medicare drug coverage (Part D) covers immunosuppressive drugs if Part B doesn't cover them. • 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 	<p><i>Except in an emergency, prior authorization may be required before you receive this service.</i></p> <p>You pay up to 20% coinsurance for Medicare Part B chemotherapy prescription drugs.</p> <p>You pay \$35 per month for covered insulin when used in an insulin pump.</p> <p>You pay up to 20% coinsurance for all other Medicare Part B non-chemotherapy prescription drugs</p> <p>Your actual coinsurance rate for each quarter may vary based on adjustment for applicable rebates supplied by Medicare. Your coinsurance will not exceed 20% for all non-insulin Medicare Part B prescription drugs.</p> <p>Part B drugs may be subject to Step Therapy requirements.</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision. • Chemotherapy • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does. • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs if the same drug is available in injectable form and the Part B ESRD benefit covers it • Calcimimetic medications under the ESRD payment system, including the intravenous medication Parsabiv[®] and the oral medication Sensipar[®] • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Procrit[®] or Retacrit[®]) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases 	

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • Parenteral and enteral nutrition (intravenous and tube feeding) <p>Part B Step Therapy Drug Categories:</p> <ul style="list-style-type: none"> • Rare Diseases • Autoimmune • Iron preparations, Parenteral • Oncology • Oncology, Supportive • Retinal Disorders • Triamcinolone Acetonide Injection • Viscosupplements • Botulinum Toxins • Endocrine Disorders <p>The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: https://www.point32health.org/provider/wp-content/uploads/sites/2/2024/09/Part-B-Step-Therapy-MNG-Medicare25.pdf</p> <p>We also cover some vaccines under our Part B prescription drug benefit.</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>

Services that are covered for you	What you must pay when you get these services
<p>Opioid treatment program services</p> <p>Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:</p> <ul style="list-style-type: none"> • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications. • Dispensing and administration of MAT medications (if applicable) • Substance use disorder counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments 	<p>You pay \$25 per encounter as part of a Medicare-covered opioid treatment program.</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 	<p><i>Except in an emergency, prior authorization may be required before you receive this service.</i></p> <p>You pay \$20 per day for Medicare-covered X-rays. You will only pay one copayment per day even if multiple X-rays are performed. There is no copay for X-rays performed and billed as part of an office or urgent care visit.</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. • Diagnostic radiology services, such as ultrasound, nuclear cardiac imaging, PET, MRI, and CT scan 	<p>You pay \$60 per day for Medicare-covered radiation therapy visits.</p> <p>You pay 20% coinsurance for Medicare-covered surgical supplies; you pay \$0 for Medicare-covered medical supplies provided as part of an office visit.</p> <p>You pay \$0 for Medicare-covered laboratory tests.</p> <p>Refer to Colorectal cancer screening in this chart for cost-sharing you pay for screening fecal-occult blood tests as part of a colorectal cancer screening exam.</p> <p>You pay \$0 for Medicare-covered blood services.</p> <p>You pay \$100 per day for a Medicare-covered ultrasound.</p> <p>You pay \$250 per day for other Medicare-covered diagnostic radiology services that are not ultrasounds. You will only pay one copayment per day even if multiple</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> Other outpatient diagnostic tests. Includes but not limited to sleep studies, EKG, stress tests, vascular studies, and breathing capacity tests. 	<p>diagnostic radiology services are performed.</p> <p>You pay \$20 per day for Medicare-covered outpatient diagnostic tests. You will only pay one copayment per day even if multiple tests are performed. There is no copay for diagnostic test services performed and billed as part of an office or urgent care visit.</p> <p>If you have multiple services performed by different providers, separate cost-sharing will apply as applicable.</p> <p>Before you receive diagnostic or therapeutic radiology services such as X-rays, ultrasound, PET, MRI, CT scan or radiation therapy services, you must first obtain a written order or prescription from either your PCP, or a specialist you have been referred to by your PCP, as applicable.</p>
<p>Outpatient hospital observation</p> <p>Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged.</p>	<p>You pay \$270 for each observation stay. If you have additional</p>

Services that are covered for you	What you must pay when you get these services
<p>For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests.</p> <p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. 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 <i>Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!</i> This fact sheet is available on the Web at https://es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.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>outpatient services while held in observation, additional cost-share may apply.</p> <p>You do not pay this outpatient hospital observation copay amount if you are admitted as an inpatient to the hospital within one day for the same condition. See Inpatient Hospital Care in this chart for more details including applicable copays.</p>
<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 	<p><i>Except in an emergency, prior authorization may be required before you receive this service.</i></p> <p>For cost shares that apply to Emergency services, see Emergency care in this chart.</p> <p>For cost shares that apply to Observation services, see Outpatient hospital observation in this chart.</p> <p>For cost shares that apply to Outpatient surgery, see Outpatient surgery, including services</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • 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 and pay the cost-sharing amounts for outpatient hospital services. 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 <i>Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!</i> This fact sheet is available on the Web at https://es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.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>provided at hospital outpatient facilities and ambulatory surgical centers in this chart.</p> <p>For cost shares that apply to Laboratory and diagnostic tests, X-rays, radiological services, and medical supplies, see Outpatient diagnostic tests and therapeutic services and supplies in this chart.</p> <p>For cost shares that apply to Mental health care and partial hospitalization, see Outpatient mental health care and Partial hospitalization services in this chart.</p> <p>For cost shares that apply to Chemical dependency care, see Outpatient substance use disorder services in this chart.</p> <p>For cost shares that apply to Drugs and biologicals that you can't give yourself, see Medicare Part B prescription drugs in this chart.</p> <p>Before you receive outpatient hospital services, you must first</p>

Services that are covered for you	What you must pay when you get these services
	obtain a referral from your PCP.
<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, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.</p>	<p>You pay \$25 for each individual or group therapy visit for Medicare-covered outpatient mental health services.</p> <p>You pay \$0 for brief office visits (up to 15 minutes) for the sole purpose of monitoring or changing drugs.</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><i>Except in an emergency, prior authorization may be required before you receive this service.</i></p> <p>You pay \$30 for each Medicare-covered physical therapy visit.</p> <p>You pay \$30 for each occupational therapy or speech/language therapy visit regardless of the outpatient setting.</p> <p>You pay \$0 for a post-outpatient surgical procedure physical therapy or occupational therapy consultation prior to discharge.</p>

Services that are covered for you	What you must pay when you get these services
	<p>Before you receive physical therapy, occupational therapy and/or speech language therapy services, you must first obtain a referral from your PCP.</p> <p>You pay \$0 for Medicare-covered cardiac and pulmonary rehabilitative therapy visits.</p> <p>Please refer to Cardiac rehabilitation services and Pulmonary rehabilitation services in this Chapter 4 for applicable referral and prior authorization requirements.</p>
<p>Outpatient substance use disorder 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 use disorder 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 \$25 for each individual or group therapy visit for Medicare-covered outpatient substance use disorder services.</p> <p>You pay \$0 for partial hospitalization services if a network provider certifies that inpatient treatment would be necessary without it.</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 <i>outpatient</i>.</p>	<p><i>Except in an emergency, prior authorization may be required before you receive this service.</i></p> <p>You pay \$0 for Medicare-covered colonoscopies.</p> <p>You pay \$170 per day for other outpatient procedures and services, including, but not limited to, diagnostic and therapeutic endoscopy, and outpatient surgery performed in an ambulatory surgical center.</p> <p>You pay \$270 per day for other outpatient procedures and services, including, but not limited to, diagnostic and therapeutic endoscopy, and outpatient surgery performed in an outpatient hospital.</p> <p>Refer to Colorectal cancer screening in this chart for cost-sharing you pay for a colorectal cancer screening exam.</p> <p>You pay no outpatient surgery copayment if you are admitted as an inpatient to the hospital</p>


Services that are covered for you	What you must pay when you get these services
	<p>for the same condition within one day after an outpatient procedure or surgery (refer to Inpatient Hospital Care in this chart for the hospital cost-share that applies instead). If you are held for observation, the copayment still applies.</p> <p>Before you receive services from a specialist you must first obtain a referral from your PCP.</p>
<p>Partial hospitalization services and Intensive outpatient services</p> <p><i>Partial hospitalization</i> is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization.</p> <p><i>Intensive outpatient service</i> is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization.</p>	<p>You pay \$0 for partial hospitalization services or intensive outpatient services if a network provider certifies that inpatient treatment would be necessary without it.</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, certified ambulatory surgical center, 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 • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member’s home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: <ul style="list-style-type: none"> ○ You have an in-person visit within 6 months prior to your first telehealth visit ○ You have an in-person visit every 12 months while receiving these telehealth services ○ Exceptions can be made to the above for certain circumstances 	<p><i>Except in an emergency, prior authorization may be required before you receive remote patient monitoring services.</i></p> <p>You pay \$0 for each covered e-visit or virtual check-in with your PCP, other primary care provider, or a Specialist.</p> <p>You pay \$10 for each covered visit or consultation in an outpatient location with your PCP or other primary care provider.</p> <p>You pay \$40 for each covered visit or consultation in an outpatient location with a specialist.</p> <p>You pay the applicable PCP or Specialist copay for surgery services furnished in the physician’s office.</p> <p>You pay the cost-sharing that applies to primary care services or specialist physician services for Medicare-covered telehealth services received from your PCP or a specialist, respectively (as described</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: <ul style="list-style-type: none"> ○ You're not a new patient and ○ The check-in isn't related to an office visit in the past 7 days and ○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours if: <ul style="list-style-type: none"> ○ You're not a new patient and ○ The evaluation isn't related to an office visit in the past 7 days, and ○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record • 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) 	<p>under this Physician/Practitioner services, including doctor's office visits section).</p> <p>You pay \$0 for visits to your PCP, RN/nurse practitioner, or anti-coagulant clinic when you are only going for INR testing (Anti-coagulant visit).</p> <p>You pay \$0 for an annual physical. If you receive services that address a medical condition during the same office visit, you pay a \$10 PCP office visit copayment.</p> <p>If you receive additional services, additional cost-share may apply.</p> <p>You pay \$0 for a follow up visit following a discharge from a hospital, SNF, Community Mental Health Centers stay, outpatient observation, or partial hospitalization that meets the Medicare requirements of Transitional Care Management (TCM) visits.</p> <p>You pay \$0 for an office visit for palliative care.</p>



Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> 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). Covered once every calendar year Follow-up office visits following discharge from hospital, SNF, Community Mental Health Centers stay, outpatient observation, or partial hospitalization 	<p>Before you receive services from a specialist you must first obtain a referral from your PCP.</p> <p>Refer to Outpatient surgery including services provided at hospital outpatient facilities and ambulatory surgical centers, in this chart for the copayment you pay for outpatient procedures and services including but not limited to diagnostic and therapeutic endoscopy and outpatient surgery in an outpatient hospital or ambulatory surgery facility.</p>
<ul style="list-style-type: none"> Additional telehealth services not covered by Medicare, including: <ul style="list-style-type: none"> Primary Care Physician Services and Other Health Care Professionals (PAs & NPs) Physician Specialist Services Individual or Group Sessions for Mental Health Specialty Services Individual or Group Sessions for Psychiatric Services Opioid Treatment Program Services Observation Services Individual or Group Sessions for Outpatient Substance Use Disorder Services 	<p>You pay \$10 for each covered telehealth visit or consultation in an outpatient location with your PCP or other primary care provider.</p> <p>You pay \$40 for each covered telehealth visit or consultation in an outpatient location with a specialist.</p> <p>You pay \$25 for each individual or group therapy visit via telehealth for Medicare-</p>


Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> ○ Kidney Disease Education Services ○ Diabetes Self-Management Training ○ Urgently Needed Services ○ Physical Therapy and Speech-Language Pathology Services ○ Remote Patient Monitoring Services ● Additional telehealth coverage includes only synchronous audio and visual consultations with your physician using a HIPAA-compliant communication software ● Additional telehealth services are covered with your existing providers from any location, or from any provider with a referral for a telemedicine visit from your PCP ● You have the option of receiving these services either through an in-person visit or via telehealth. If you choose to receive one of these services via telehealth, you must use a network provider that currently offers the service via telehealth 	<p>covered outpatient mental health services.</p> <p>You pay \$25 for each telehealth encounter as part of a Medicare-covered opioid treatment program.</p> <p>You pay \$270 per stay for telehealth observation services. If you receive additional outpatient services while held in observation, additional cost-share may apply.</p> <p>You pay \$25 for each individual or group therapy visit via telehealth for Medicare-covered outpatient substance use disorder services.</p> <p>You pay \$0 for Medicare-covered kidney disease education services via telehealth.</p> <p>You pay \$0 for Medicare-covered diabetes self-management training services via telehealth.</p> <p>You pay \$45 for each urgently needed service received via telehealth.</p>

Services that are covered for you	What you must pay when you get these services
	<p>You pay \$30 for each physical therapy and speech-language pathology service received via telehealth.</p> <p>You pay \$0 for remote patient monitoring services rendered by your PCP or Specialist.</p> <p>Before you receive additional telehealth services from a specialist you must first obtain a referral from your PCP.</p>
<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, but not limited to, diabetes) 	<p>You pay \$40 for each Medicare-covered visit.</p> <p>Before you receive podiatry services, you must first obtain a referral from your PCP.</p>
<p> Prostate cancer screening exams</p> <p>For men aged 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 and orthotic 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 testing, fitting, or training in the use of prosthetic and orthotic devices; as well as: 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 and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – see Vision Care later in this section for more detail.</p> <p>Note:</p> <ul style="list-style-type: none"> • For coverage, the device/supplies must be covered by the plan; medically necessary; provided by an in-network DME or Orthotics and Prosthetics (O&P) supplier in your PCP’s referral circle; and in some instances, have a prior authorization on file. • For help determining whether devices/supplies are covered, and/or whether prior authorization is required, and/or whether a DME or Orthotics and Prosthetics (O&P) supplier is in our network, call Member Services. <p>Lymphedema Compression Treatment Items</p> <p>The plan covers lymphedema compression treatment items up to 12 garments and related accessories every 6 months for members with any diagnosis of lymphedema. The lymphedema compression treatment items must be prescribed by a physician (or a physician assistant, nurse practitioner, or a clinical nurse specialist). Lymphedema compression treatment items for any non-lymphedema diagnosis are not covered.</p>	<p><i>Except in an emergency, prior authorization may be required before you obtain prosthetic devices and related supplies.</i></p> <p>You pay 20% coinsurance upon written prescription from a network provider to a network DME or Orthotics and Prosthetics (O&P) supplier in your PCP’s referral circle.</p> <p>Qualification for each item is dependent on the listed criteria.</p> <p><i>Except in an emergency, prior authorization may be required before you obtain these items.</i></p>

Services that are covered for you	What you must pay when you get these services
<p>The items must be furnished by an enrolled Durable Medical Equipment, Prosthetic Devices, Prosthetics, Orthotics, & Supplies (DMEPOS) supplier. All suppliers, including physical therapists and other practitioners furnishing bandaging systems must be enrolled as a DMEPOS supplier to be paid for furnishing lymphedema compression treatment items. The following categories of lymphedema compression treatment items are covered when determined to be reasonable and necessary for the treatment of lymphedema:</p> <ul style="list-style-type: none"> • Standard daytime gradient compression garments • Custom daytime gradient compression garments • Nighttime gradient compression garments • Gradient compression wraps with adjustable straps • Accessories (e.g., zippers, linings, padding or fillers, etc.) necessary for the effective use of a gradient compression garment or wrap • Compression bandaging supplies • Other items determined by CMS to be lymphedema compression treatment items <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 20% coinsurance upon written prescription from a network provider to a network DME or Orthotics and Prosthetics (O&P) supplier in your PCP's referral circle.</p> <p>Qualification for each item is dependent on the listed criteria.</p> <p>You pay 20% coinsurance for Medicare-covered medical supplies; you pay \$0 for Medicare-covered medical supplies provided as part of an office visit.</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 a referral for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.</p>	<p><i>Except in an emergency, prior authorization may be required before you receive this service.</i></p> <p>You pay \$0 for Medicare-covered services.</p> <p>Before you receive this service, 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> 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 lung cancer with low dose computed tomography (LDCT)</p> <p>For qualified individuals, a LDCT is covered every 12 months.</p> <p>Eligible members are: people aged 50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive an order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner.</p> <p><i>For LDCT lung cancer screenings after the initial LDCT screening:</i> the members must receive an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT.</p>


Services that are covered for you	What you must pay when you get these services
<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 provider. We cover these tests once every 12 months or at certain times during pregnancy.</p> <p>We also cover up to two 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 provider 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 for STIs preventive benefit.</p>
<p>Services to treat kidney disease</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, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies 	<p>You pay 20% coinsurance for Medicare-covered dialysis services within the service area when ordered by your PCP.</p> <p>There is no coinsurance for kidney disease education services.</p> <p>No referral is required for dialysis services.</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> 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, Medicare Part B prescription drugs.</p>	
<p>Skilled nursing facility (SNF) care</p> <p>(For a definition of skilled nursing facility care, see Chapter 10 of this document. 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"> Semi-private 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 with the first pint of blood that you need. Medical and surgical supplies ordinarily provided by SNFs 	<p><i>Except in an emergency, prior authorization may be required before you receive this service.</i></p> <p>For each admission you pay \$20 per day for days 1-20 of a benefit period, and \$160 per day for days 21-44 of a benefit period, and \$0 per day for days 45-100 of a benefit period.</p> <p>A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • 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 pay in-network cost-sharing for 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 or domestic partner is living at the time you leave the hospital 	<p>benefit periods you can have.</p>
<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, however, you will pay the applicable cost-sharing. Each counseling attempt includes up to four face-to-face visits.</p> <p>Smoking cessation telephonic counseling is also available through the Massachusetts Tobacco Cessation and Prevention Program (MTCP). MTCP is a free, evidence-based stop-</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.</p>

Services that are covered for you	What you must pay when you get these services
<p>smoking service developed by the Massachusetts Department of Public Health.</p> <p>If you are ready to quit or are thinking about it, ask your doctor about the Massachusetts Tobacco Cessation and Prevention Program (MTCP) or visit www.mass.gov/take-the-first-step-toward-a-nicotine-free-life, or call 1-800-QUIT-NOW (1-800-784-8669).</p>	
<p>Special Supplemental Benefits for the Chronically Ill (SSBCI)</p> <p>Tufts Medicare Preferred Care Management program includes the additional benefits described below for members with qualifying chronic condition(s), as applicable:</p> <ul style="list-style-type: none"> • Non-emergency transportation by ride-share services or van with plan approved vendor to doctor appointments or other plan-approved locations. • Pulse oximeter supplied by plan approved DME vendor. <p>Chronic Conditions covered are:</p> <ul style="list-style-type: none"> • Congestive heart failure (CHF) • Chronic obstructive pulmonary disease (COPD) • Diabetes • Dementia • End-stage renal disease (ESRD) • Stroke and related conditions <p>Chronic diseases are generally conditions that require ongoing medical attention or limit activities of daily living. The condition is diagnosed by a licensed medical professional, including your primary care physician, nurse practitioner and similar providers.</p>	<p>You pay \$0 for covered non-emergency transportation, subject to the following limits:</p> <ul style="list-style-type: none"> • 3 round trip rides per week (156 round trip rides per year) for members with ESRD. • 12 round trip rides per year for non-ESRD members diagnosed with any of the other covered Chronic Condition(s). • Maximum of 75 miles for each round trip. <p>You pay 20% coinsurance for a covered pulse oximeter. Coverage is limited to one pulse oximeter per year per member as determined by the Care Manager.</p>

Services that are covered for you	What you must pay when you get these services
<p>To be eligible, a member must be diagnosed with one or more of the above chronic conditions and must also participate in the Tufts Medicare Preferred Care Management program.</p> <p>To access these benefits, Care Managers will work with eligible members to assess the member's needs and, if necessary, refer the member to the appropriate plan approved vendor for the appropriate eligible benefit(s).</p> <p>Call Member Services if you have questions about this benefit or would like to find out about participating in the Tufts Medicare Preferred Care Management program.</p>	
<p>Supervised Exercise Therapy (SET)</p> <p>SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment.</p> <p>Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.</p> <p>The SET program must:</p> <ul style="list-style-type: none"> • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques 	<p><i>Except in an emergency, prior authorization may be required before you receive this service.</i></p> <p>You pay \$0 for Medicare-covered Supervised Exercise Therapy services.</p> <p>Before you receive this service, 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>SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.</p>	
<p>Urgently needed services</p> <p>A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service if either you are temporarily outside the service area of the plan, or even if you are inside the service area of the plan, it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts. Your plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable.</p> <p>Your plan includes worldwide coverage for urgently needed care.</p>	<p>You pay \$45 for each Medicare-covered urgent care visit. This copayment is not waived if you are admitted as an inpatient to the hospital within one day for the same condition.</p> <p>See the Emergency Care section in this Medical Benefits Chart for cost shares that apply to an urgently needed care visit to an emergency room.</p>
<p> Vision care</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • 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 <p>Note:</p> <ul style="list-style-type: none"> • Services for the diagnosis and treatment of cataract are considered diagnostic, and the copayment amount described in this section will apply. 	<p>You pay \$40 for each Medicare-covered outpatient visit for services to diagnose and/or treat a disease or condition of the eye.</p> <p>Before you receive services from an ophthalmologist for diagnosis and/or treatment of a medical condition of the eye,</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • Please see additional information below for coverage of routine eye exams. • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year 	<p>you must first obtain a referral from your PCP.</p> <p>No referral is required to see an optometrist, but you must use a provider in the EyeMed Vision Care network.</p> <p>You pay \$0 for an annual glaucoma screening if you are at high risk. If you receive this service as part of an office visit that addresses a medical condition, you pay a \$40 specialist office visit copayment.</p> <p>You pay \$15 if the screening is received as part of an annual routine exam. You pay \$40 if the screening is received as part of a service that addresses other medical conditions.</p> <p>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.</p> <p>No referral is required to see an optometrist, but you must use a provider</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> One pair of eyeglasses 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. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) (Tints, anti-reflective coating, U-V lenses, or oversize lenses are covered only when deemed medically necessary by the treating physician.) <p>Note: Coverage includes standard fitting and follow up after insertion of contact lenses as follows:</p> <ul style="list-style-type: none"> Members will receive an initial contact lens fitting and up to 2 follow up visits are available once a comprehensive eye exam has been completed. Member must complete the follow up within 45 calendar days of the fitting, and the fitting and follow up must be done by the same provider. <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 for Keratoconus, Anisometropia, High Myopia, Aphakia, Congenital Aphakia, or Pseudoaphakia. 	<p>in the EyeMed Vision Care network.</p> <p>You pay \$0 for one pair of Medicare-covered standard eyeglasses with standard frames or contact lenses after cataract surgery when obtained from a provider in the EyeMed Vision Care network. You may use your eyewear allowance through EyeMed to purchase upgrades (i.e., non-standard frames and/or lenses) for your Medicare-covered eyewear. Once your eyewear allowance is exhausted, however, you will be responsible for any remaining balance.</p> <p>No referral is required for this service, but you must obtain covered eyewear from a provider in the EyeMed Vision Care network.</p> <p>You pay \$0 for one pair of standard eyeglasses with standard frames or contact lenses for Keratoconus, Anisometropia, High Myopia, Aphakia, Congenital Aphakia,</p>

Services that are covered for you	What you must pay when you get these services
<p>Note: Coverage includes standard fitting and follow up after insertion of contact lenses as follows:</p> <ul style="list-style-type: none"> Members will receive an initial contact lens fitting and up to 2 follow up visits are available once a comprehensive eye exam has been completed. Member must complete the follow up within 45 calendar days of the fitting, and the fitting and follow up must be done by the same provider. 	<p>or Pseudoaphakia. You may use your eyewear allowance through EyeMed to purchase upgrades (i.e., non-standard frames and/or lenses) for your therapeutic eyewear. Once your eyewear allowance is exhausted, however, you will be responsible for any remaining balance.</p> <p>No referral is required for this service, but you must obtain covered eyewear from a provider in the EyeMed Vision Care network.</p>
<ul style="list-style-type: none"> One routine eye exam each calendar year 	<p>You pay \$15 for one annual routine eye exam. If you receive services that address a medical condition during the same office visit, you pay a \$40 specialist office visit copayment. Eye refractions are not covered if billed separately from the routine eye exam. Refractions are not covered except when included and billed as a component of the routine eye exam.</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> Standard eyeglasses (prescription lenses, frames, or a combination of lenses and frames) and/or contact lenses including upgrades every calendar year. This benefit cannot be combined with the standard eyeglasses/contact lenses benefits described in the fourth and fifth bullet points listed above. <p>The annual allowance may be used to purchase upgrades for Medicare-covered and/or therapeutic eyewear as well as routine/corrective eyewear.</p> <p>To contact EyeMed Vision Care if you have any questions about this benefit, call 1-866-591-1863.</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> <p>To access the annual eyewear benefit, you may purchase eyewear from any provider.</p> <p>If you choose an EyeMed Vision Care participating provider, you have the benefit of \$150 per calendar year applied at the time of service, and would be responsible to pay for any remaining balance. The EyeMed Vision Care provider will process the claim.</p> <p>If you use a non-participating provider, you would need to pay out of pocket and submit for reimbursement. You would be reimbursed up to \$90 per calendar year. You must file a claim with EyeMed Vision Care to get reimbursed.</p>

Services that are covered for you	What you must pay when you get these services
	<p>Call Member Services for the claim form.</p> <p>Sale items are excluded, and this benefit cannot be combined with any other store discounts, coupons, or promotional codes. If the cost of the glasses exceeds the benefit limit, you are responsible for all additional charges.</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 five bullet points. Call Member Services if you have questions about your vision benefits.</p>
<p> Welcome to Medicare preventive visit</p> <p>The plan covers the one-time <i>Welcome to Medicare</i> 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 (or vaccines)), and referrals for other care if needed.</p> <p>Important: We cover the <i>Welcome to Medicare</i> preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office</p>	<p>There is no coinsurance, copayment, or deductible for the <i>Welcome to Medicare</i> preventive visit.</p>

Services that are covered for you	What you must pay when you get these services
<p>know you would like to schedule your <i>Welcome to Medicare</i> preventive visit.</p>	
<p>Wigs</p> <p>Wigs are covered for members who experience hair loss due to treatment for cancer.</p> <p>To obtain this reimbursement, please submit a member reimbursement form along with proof of payment and any additional information outlined on the form. Proof of payment must be in the member's name or, alternatively, in the name of the member's representative on record. Call Member Services to request a reimbursement form or go to our website www.thpmp.org. Send the completed form with any required documents to the address shown on the form. If you have any questions, contact Member Services.</p>	<p>Plan covers up to \$500 per calendar year.</p> <p>To access the wig benefit, you may purchase the wig from any provider.</p> <p>If you choose a participating provider, you have the benefit of \$500 per calendar year applied at the time of service, and would be responsible to pay for any remaining balance.</p> <p>Additionally, you have access to discounted rates if using a participating provider. Participating providers can be found in the <i>Provider Directory</i>.</p> <p>If you use a non-participating provider, you would need to pay out of pocket and submit for reimbursement. You must file a claim with the plan to get reimbursed. Call Member Services for the claim form.</p> <p>If the cost of the wig exceeds the benefit</p>

Services that are covered for you	What you must pay when you get these services
	limit (\$500), you are responsible for all additional charges. No referral is required for this benefit.

Section 2.2 Extra optional supplemental benefits you can buy

Our plan offers some extra benefits that are not covered by Original Medicare and not included in your benefits package. These extra benefits are called **Optional Supplemental Benefits**. If you want these optional supplemental benefits, you must sign up for them and you may have to pay an additional premium for them. The optional supplemental benefits described in this section are subject to the same appeals process as any other benefits.

The Tufts Medicare Preferred Dental Option is an optional supplemental benefit package. This dental coverage is not covered by Original Medicare and not included in your benefit package as a plan member. If you want this optional supplemental benefit, you must sign up for it, and pay an additional premium. The optional supplemental benefits described in this section are subject to the same appeals process as any other benefits. This supplemental benefit is administered by Dominion National and is available to members who have enrolled in Tufts Medicare Preferred HMO plans.

If you have additional questions about the Tufts Medicare Preferred Dental Option, please call the Member Services number listed on the back cover of this document.

How Does the Tufts Medicare Preferred Dental Option Work?

Benefits are provided under the Tufts Medicare Preferred Dental Option only for services provided by a dentist who participates in the Dominion PPO Network. Any amount that you may be required to pay your network dentist is explained in the Tufts Medicare Preferred Dental Option Benefit Chart below. Services rendered by non-participating providers will not be covered.

You need to show your dental member identification card when you go for your dental appointment. Your Dominion PPO Network dentist will file the claim directly with Dominion once services have been furnished. Dominion will make payments directly to the Dominion PPO Network dentist.

Contact Member Services at the number listed on the back cover of this document for any questions you have about dental claims.

How to choose a Dominion PPO Network dentist?

A network dentist is a licensed dentist that had entered into an agreement with Dominion to furnish services to its covered individuals. To see if your dentist is a Dominion PPO Network dentist or if you need a new dentist, review the *Dental Directory* located at www.thpmp.org/dentist, or contact the Member Services number listed on the back cover of this document.

Tufts Medicare Preferred Dental Option Covered Dental Services

Covered dental services are subject to the limitations and exclusions described in this section. Dental Services described in this section are covered dental services when such services are provided by a participating provider in the Dominion PPO Network. No prior authorizations are required under this plan.

Optional Supplemental Benefit: Tufts Medicare Preferred Dental Option	What you must pay when you get these services
<p>Tufts Medicare Preferred Dental Option*</p> <p>The Tufts Medicare Preferred Dental Option is an optional supplemental benefit that you must sign up for and pay an additional premium. With this plan, you get preventive services, including X-rays, routine cleanings and check-ups. You are also covered for minor and major restorative dental services with no waiting period.</p> <p>The plan pays up to the Calendar Year Maximum of \$1,000 for all covered supplemental dental services. Services received from a dentist in an emergency situation are subject to plan rules and cost-sharing.</p> <p>Supplemental dental services are covered with providers in the Dominion PPO Network <i>only</i>. To see if your dentist is a Dominion PPO Network dentist or if you need a new dentist, review the <i>Dental Directory</i> located at www.thmp.org/dentist, or contact the Member Services number listed on the back cover of this document.</p> <p>The Tufts Medicare Preferred Dental Option <i>enhances</i> your dental coverage by reducing cost-sharing for Class 2 Basic services and adding coverage for Class 3 Major services. If you enroll in the Tufts Medicare Preferred Dental Option, the dental coverage described in section 2.1 (<i>Medical Benefits Chart</i>, Tufts Medicare Preferred Dental Plan) does not apply to you.</p>	<p>You pay an additional monthly premium amount of \$37.00.</p> <p>Cost-sharing information is provided below based on the class of dental services you receive.</p> <p>Refer to the following sections below for additional important information:</p> <p>Pre-Treatment Estimates for explanation of how to seek <i>Pre-Treatment Estimates</i> before receiving dental care.</p> <p>Limitations and Exclusions for <i>Limitations and Exclusions</i> that apply to both the Tufts Medicare Preferred Dental <u>Plan</u> (for no additional premium, described in Section 2.1 of this chapter) and the Tufts Medicare Preferred Dental <u>Option</u> (for an</p>

* Cost-shares for these items/services do not count toward your annual maximum out-of-pocket amount.

Optional Supplemental Benefit: Tufts Medicare Preferred Dental Option	What you must pay when you get these services
<p><u>Class 1 Diagnostic and Preventive Services</u></p> <p>Comprehensive Oral Exam (including the initial dental history and charting of teeth) covered once every 36 months</p> <p>Periodic Oral Evaluation covered twice per year.</p> <p>Intra oral bitewing X-rays images (X-rays of the crowns of the teeth) covered twice per year when oral conditions indicate need.</p> <p>Prophylaxis (routine cleaning, scaling and polishing of teeth) covered twice per year.</p>	<p>additional premium, described in this section).</p> <p>You pay \$0 for Class 1 Diagnostic and Preventive Services</p>

Optional Supplemental Benefit: Tufts Medicare Preferred Dental Option	What you must pay when you get these services
<p><u>Class 2 Basic Services</u></p> <p>Emergency oral evaluation problem focused exams covered once every 12 months.</p> <p>Intra oral X-ray image of the entire mouth (panoramic image) covered once every 60 months.</p> <p>Intra oral X-ray image of the entire mouth (full mouth series) covered once every 60 months.</p> <p>Single tooth X-ray images covered as needed.</p> <p>Silver fillings and white fillings covered once every 24 months per surface, per tooth.</p> <p>Periodontal cleaning covered once every 6 months following active periodontal therapy, not to be combined with regular cleanings.</p> <p>Scaling and root planing covered once every 24 months, per quadrant.</p> <p>Scaling in presence of generalized moderate/severe gingival inflammation covered once every 24 months after oral evaluation and in lieu of a covered prophylaxis.</p> <p>Full mouth debridement covered once per lifetime.</p> <p>Simple extractions covered once per tooth.</p> <p>Minor treatment for pain relief covered only if no services other than exam and X-rays were performed on the same date of service.</p>	<p>You pay 20% coinsurance for Class 2 Basic Services</p>

Optional Supplemental Benefit: Tufts Medicare Preferred Dental Option	What you must pay when you get these services
<p><u>Class 3 Major Services</u></p> <p>Protective restorations are covered once per tooth.</p> <p>Oral Surgery</p> <p>Surgical extractions are covered once per tooth.</p> <p>Periodontics</p> <p>Periodontal surgery: One surgical procedure is covered per lifetime; gingivectomy or gingivoplasty and osseous surgery are covered as needed.</p> <p>Bone grafts and guided tissue regeneration are covered once per lifetime.</p> <p>Endodontics</p> <p>Root canal treatment covered once per tooth per lifetime.</p> <p>Apicoectomy covered as needed.</p> <p>Retreatment root canal therapy covered once per tooth per lifetime at least 24 months after initial root canal therapy.</p> <p>Prosthetic Maintenance</p> <p>Bridge or denture repair covered once every 24 months per bridge or denture.</p> <p>Tissue conditioning covered one treatment per denture every 84 months.</p> <p>Adding teeth to existing partial or full dentures covered once per tooth, per denture per 24 months.</p> <p>Rebase or reline of dentures is covered once per denture every 24 months.</p>	<p>You pay 50% coinsurance for Class 3 Major Services</p>

Optional Supplemental Benefit: Tufts Medicare Preferred Dental Option	What you must pay when you get these services
<p><u>Class 3 Major Services continued</u></p> <p>Adjunctive Services (provided in conjunction with the primary treatment)</p> <p>Local Anesthesia and inhalation of nitrous oxide/analgesia, anxiolysis are provided in conjunction with covered oral surgery or periodontal surgery and are integral to the primary treatment.</p> <p>Prosthodontics</p> <p>Complete or partial dentures are covered one per arch within 84 months.</p> <p>Fixed bridges covered once per 84 months.</p> <p>Note: A posterior fixed bridge and a removable denture are not covered in the same arch within 84 months; if a denture in the same arch as the fixed bridge was covered within 84 months, there will be no benefit for the fixed bridge.</p> <p>Temporary partial dentures covered once per 84 months (to replace any of the six upper or lower front teeth, but only if the temporary partial dentures are installed immediately following the loss of teeth during the period of healing).</p>	<p>You pay 50% coinsurance for Class 3 Major Services</p>

Optional Supplemental Benefit: Tufts Medicare Preferred Dental Option	What you must pay when you get these services
<p><u>Class 3 Major Services continued</u></p> <p>Major Restorative (teeth must have good prognosis)</p> <p>Initial placement of crowns and onlays is covered once within 84 months per tooth, when teeth cannot be restored with regular filings due to fracture or decay. Implant supported crowns are not covered services.</p> <p>Recement of crowns and onlays is covered once per tooth per 12 months.</p> <p>Inlays covered once per tooth per 84 months.</p> <p>Post and core or crown buildup, when needed to retain a crown on a tooth with excessive breakdown due to caries and/or fractures, is covered once per tooth every 84 months.</p>	<p>You pay 50% coinsurance for Class 3 Major Services</p>

When can you enroll in the Tufts Medicare Preferred Dental Option?

- At the time of initial enrollment in a Tufts Medicare Preferred HMO plan (for newly eligible beneficiaries)
- Within the first month of your initial enrollment in Tufts Medicare Preferred HMO plan (coverage will be effective the first of the following month)
- During the Annual Election Period (October 15 – December 7 of each year) for a start date of January 1 of the following year
- From January 1 – January 31 for an effective date of February 1
- At the time of enrollment in a Tufts Medicare Preferred HMO plan during a Special Election Period
- Within the first month of your enrollment in a Tufts Medicare Preferred HMO plan during a Special Election Period (coverage will be effective the first of the following month)

How can you enroll in the Tufts Medicare Preferred Dental Option?

If you are new to this Tufts Medicare Preferred plan, you would complete the enrollment application when enrolling into medical coverage and choose the Tufts Medicare Preferred Dental Option for an additional monthly premium (premium amounts are listed in the table at the beginning of this section).

If you are an enrolled or current Tufts Medicare Preferred HMO member, you would need to complete a Tufts Medicare Preferred Dental Option Enrollment Form to enroll in the Tufts Medicare Preferred Dental Option for an additional monthly premium. You can enroll by mail, by calling Member Services at 1-800-701-9000 (TTY: 711) or on our website www.thpmp.org.

Your dental premium must be paid the same way you pay your medical premium. Please refer to Chapter 1, Section 5.1 of this *Evidence of Coverage*, *There are several ways you can pay your plan premium*, for more information about your payment options.

How to disenroll from the Tufts Medicare Preferred Dental Option

You may voluntarily disenroll from the Tufts Medicare Preferred Dental Option at any time throughout the year with advance notice, in one of three ways:

- by calling our Member Services department (phone numbers are listed on the back of this document),
- by mailing or faxing the disenrollment form from the website, -OR-
- by mailing or faxing a signed letter requesting disenrollment. Your letter must clearly state that you wish to disenroll from Tufts Medicare Preferred Dental Option and include your printed name and Tufts Medicare Preferred member ID number.

Contact Member Services if you need more information on how to disenroll using these options. Your disenrollment will be effective on the first day of the month following receipt of your phone call requesting disenrollment or your completed and signed disenrollment request.

Disenrolling from the Tufts Medicare Preferred Dental Option does not impact your enrollment in your Tufts Medicare Preferred HMO plan.

If you disenroll from the Tufts Medicare Preferred Dental Option, you cannot re-enroll in the Tufts Medicare Preferred Dental Option until the next Optional Supplemental Benefits election period.

The Optional Supplemental Benefits election periods are shown earlier in this section under **When can you enroll in the Tufts Medicare Preferred Dental Option?**

If you disenroll from the Tufts Medicare Preferred HMO Basic No Rx plan, you will automatically be disenrolled from the Tufts Medicare Preferred Dental Option.

No additional premium will be collected for the Tufts Medicare Preferred Dental Option once you are disenrolled from the Optional Supplemental Benefit. If you paid for additional months, you will receive a refund.

Your premium for the Tufts Medicare Preferred Dental Option is due on the 15th of each month. This is the same date your premium for your Tufts Medicare Preferred HMO coverage (if applicable) and/or Part D Late Enrollment Penalty is due. All premium payments apply first to your medical coverage, and the remainder will apply to your Tufts Medicare Preferred Dental

Option. If you fail to pay the monthly premium for the Tufts Medicare Preferred Dental Option but you do pay enough to meet your monthly premium for your Tufts Medicare Preferred HMO plan, you will lose the optional supplemental benefits included in the Tufts Medicare Preferred Dental Option, but will remain enrolled in your Tufts Medicare Preferred HMO plan. You will be notified in writing if the Tufts Medicare Preferred Dental Option is removed from your Tufts Medicare Preferred HMO coverage.

If you fail to pay your full Tufts Medicare Preferred HMO plan premium, you may be at risk for disenrollment. Please see Section 5.1 in Chapter 8 of this *Evidence of Coverage* for additional information regarding failure to pay plan premiums. If you are disenrolled from the Tufts Medicare Preferred Dental Option, you cannot re-enroll in the Tufts Medicare Preferred Dental Option until the next Annual Election Period or if you qualify for a Special Election Period, and you will be responsible for any outstanding balance.

Pre-treatment Estimates

If the charge for dental treatment will exceed three hundred dollars (\$300) it is recommended that the dentist file a copy of the treatment plan with Dominion BEFORE the treatment begins. A treatment plan is a detailed description of the procedures that the dentist plans to perform and includes an estimate of the charges for each service. The pre-treatment estimate will be reviewed and a pre-treatment estimate statement will be issued to you or the Provider detailing the benefits that will be covered by your plan along with your estimated responsibility and potential payment to the dental office. The pre-treatment estimate is based on eligibility and benefits available at the time it is processed. A pre-treatment estimate is not required to obtain care.

A pre-treatment estimate is not a guarantee of payment. The claim for services performed will be based on eligibility and available benefits at the time it is submitted for payment and other procedures performed especially in the same area/quadrant/tooth which could all affect the actual claim determination/payment.

Limitations and Exclusions:

Payment is subject to the plan benefits (e.g., Calendar Year Maximum), limitations and exclusions at the time the claim is submitted.

If a method of treatment is more costly than is customarily provided, benefits will be paid on the least costly method of treatment, and you will be responsible for the remaining balance.

Coverage is limited to those services listed in the Tufts Medicare Preferred Dental Option Benefit Chart above. If a service is not listed, it is not covered.

Services that are not covered include, but are not limited to:

- Services and treatments not listed in the Evidence of Coverage are not covered by the Plan. If a member receives a non-covered service, the member will be responsible for the full payment of the non-covered service.

- Dental expenses incurred in connection with any dental procedures started prior to the effective date of coverage are excluded. The replacement of teeth missing prior to the effective date of coverage is not covered.
- Services which are covered under worker's compensation or employer's liability laws.
- Services which are not necessary for the patient's dental health as determined by the plan.
- Reconstructive, plastic, cosmetic, elective or aesthetic dentistry.
- Oral surgery requiring the setting of fractures and dislocations.
- Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, mandibular prognathism or developmental malformations where such services should not be performed in a dental office.
- Dispensing of drugs.
- Hospitalization for any dental procedure.
- Treatment required for conditions resulting from major disaster, epidemic, war, acts of war, whether declared or undeclared, or while on active duty as a member of the armed forces of any nation or from war or acts of war, whether declared or undeclared.
- Replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function.
- Diagnosis or treatment of Temporomandibular Disorder (TMD) and/or occlusal disharmony.
- Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth, including third molars.
- Implants and related services, including implant removal; replacement of lost, stolen or damaged prosthetic or orthodontic appliances; athletic mouth guards; precision or semi-precision attachments; denture duplication; periodontal splinting of teeth.
- Services for increasing vertical dimension, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions.
- Procedures, that in the opinion of the plan, are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the Member's condition.
- Treatment of cleft palate, malignancies, or neoplasms.
- Any service or supply rendered to replace a tooth lost prior to the effective date of coverage. This exclusion expires after 36 months of member's continuous coverage under the plan.

Tufts Medicare Preferred Dental Option is powered by Dominion.

The Tufts Medicare Preferred Dental Option is administered by Dominion Dental Services, Inc., which operates under the trade name Dominion National.

SECTION 3 What services are not covered by the plan?

Section 3.1 Services we do *not* cover (exclusions)

This section tells you what services are *excluded* from Medicare coverage and therefore, are not covered by this plan.

The chart below lists services and items that either are not covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you receive the excluded services at an emergency facility, the excluded services are still not covered and our plan will not pay for them. The only exception is if the service is appealed and decided upon appeal to be a medical service 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 7, Section 5.3 in this document.)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Acupuncture		<ul style="list-style-type: none">• Available for people with chronic low back pain under certain circumstances.• Additional acupuncture services are eligible for reimbursement under the Wellness Allowance. See Wellness Allowance benefit description for full details.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Cosmetic surgery or procedures		<ul style="list-style-type: none"> • Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. • Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
<p>Custodial care</p> <p>Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.</p>	Not covered under any condition	
<p>Experimental medical and surgical procedures, equipment and medications.</p> <p>Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.</p>		<ul style="list-style-type: none"> • May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. <p>(See Chapter 3, Section 5 for more information on clinical research studies.)</p>
Extended care bed holds.	Not covered under any condition	
Fees charged for care by your immediate relatives or members of your household.	Not covered under any condition	
Full-time nursing care in your home.	Not covered under any condition	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Home-delivered meals		<ul style="list-style-type: none"> Covered up to 2 meals per day for 14 days post discharge. See Meals Post-Hospitalization/Rehabilitation in Section 2.1 of this “Medical Benefits Chart” for full details.
Home Health Aide services without any other skilled services in place.	Not covered under any condition	
Home Health Care services such as continuous Home Health Aide or Skilled Nursing for more than 2 hours at a time.	Not covered under any condition	
Homemaker services include basic household assistance, including light housekeeping or light meal preparation.	Not covered under any condition	
Naturopath services (uses natural or alternative treatments).	Not covered under any condition	
Non-routine dental care		<ul style="list-style-type: none"> Dental care required to treat illness or injury may be covered as inpatient or outpatient care. Additional services may be covered under the Tufts Medicare Preferred Dental Plan, or if member elects to purchase the Tufts Medicare Preferred Dental Option.
Orthopedic shoes or supportive devices for the feet		<ul style="list-style-type: none"> Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	Not covered under any condition	
Private room in a hospital.		<ul style="list-style-type: none"> • Covered only when medically necessary.
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	Not covered under any condition	
Routine chiropractic care		<ul style="list-style-type: none"> • Manual manipulation of the spine to correct a subluxation is covered. • Initial evaluation covered once per calendar year.
Routine dental care, such as cleanings, fillings or dentures.		<ul style="list-style-type: none"> • Additional services may be covered under the Tufts Medicare Preferred Dental Plan, or if member elects to purchase the Tufts Medicare Preferred Dental Option.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids.		<ul style="list-style-type: none"> • Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery (but excludes scratch resistant coatings, mirror coatings, polarized lenses, deluxe lens features and progressive lenses.) • Routine eye exam is covered once per calendar year. • Standard eyeglasses (prescription lenses, frames, a combination of lenses and frames) and/or contact lenses, including upgrades covered every calendar year up to \$150 allowance from an EyeMed Vision Care participating provider, or up to \$90 from a non-participating provider.
Routine foot care		<ul style="list-style-type: none"> • Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes).
Routine hearing exams, hearing aids, or exams to fit hearing aids.		<ul style="list-style-type: none"> • Routine hearing exam is covered once per calendar year. • Hearing aid evaluation and fitting from a Hearing Care Solutions provider is covered. • Coverage includes up to 2 aids per year, 1 aid per ear, from Hearing Care Solutions providers only.
Services considered not reasonable and necessary, according to Original Medicare standards.	Not covered under any condition	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
<p>Transportation, except by ambulance as described in this chapter, section 2.1. If you choose to use an ambulance when it is not a Medicare-covered service, you will be responsible for the entire cost. Wheelchair van (chair car) transportation is not covered even if provided by an ambulance company.</p>		<ul style="list-style-type: none"> • Non-ambulance transportation (e.g., by chair car/wheelchair van or sedan) through the plan-approved vendor from a hospital to a skilled nursing facility (SNF) or to your home. • Members with certain chronic conditions receive additional non-emergency transportation to appointments and other plan-approved locations (e.g., by ride-share services and vans) through the plan-approved vendor. <p>See Special Supplemental Benefits for the Chronically Ill in Section 2.1 of this “Medical Benefits Chart” for full details.</p>

CHAPTER 5:

*Asking us to pay our share of
a bill you have received for
covered medical services*

SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered services

Sometimes when you get medical care, you may need to pay the full cost. Other times, you may find that you have paid more than you expected under the coverage rules of the plan or you may receive a bill from a provider. In these cases, 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 more than your share of the cost for medical services that are covered by our plan. There may be deadlines that you must meet to get paid back. Please see Section 2 of this chapter.

There may also be times when you get a bill from a provider for the full cost of medical care you have received or possibly for more than your share of cost sharing as discussed in this document. First try to resolve the bill with the provider. If that does not work, send the bill to us instead of paying it. 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 we decide not to pay it, we will notify the provider. You should never pay more than plan-allowed cost sharing. If this provider is contracted you still have the right to treatment.

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

Outside the service area, you can receive emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases,

- You are only responsible for paying your share of the cost for emergency or urgently needed services. Emergency providers are legally required to provide emergency care. If you pay the entire amount yourself at the time you receive the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
- 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 more than your share of the cost of the service, we will determine how much you are owed and pay you back for our share of the cost.

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

Network providers should always bill the plan directly and ask you only for your share of the cost. But sometimes they make mistakes and ask you to pay more than your share.

Chapter 5. Asking us to pay our share of a bill you have received for covered medical services

- You only have to pay your cost-sharing amount when you get covered services. 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 that you think is more than you should pay, 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, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

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 after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork (such as receipts and bills) for us to handle the reimbursement.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 7 of this document 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

You may request us to pay you back by sending us a request in writing. If you send a request in writing, send 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 (www.thpmp.org) or call Member Services and ask for the form.

Chapter 5. Asking us to pay our share of a bill you have received for covered medical services

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

Tufts Medicare Preferred
Claims Department
P.O. Box 518
Canton, MA 02021-1166

EyeMed Payment Requests:

First American Administrators
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

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 and how much we owe

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 is covered and you followed all the rules, we will pay for our share of the cost. If you have already paid for the service, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service yet, we will mail the payment directly to the provider.

If we decide that the medical care is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. We will send you a letter explaining the reasons why we are not sending the payment and your right to appeal that decision.

Section 3.2 If we tell you that we will not pay for all or part of the medical care, you can make an appeal

If you think we have made a mistake in turning down your request for payment or 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. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 7 of this document.

CHAPTER 6:

Your rights and responsibilities

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

Section 1.1 We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, in braille, in large print, or other alternate formats, etc.)

Your plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how a plan may meet these accessibility requirements include, but are not limited to, provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in braille, large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services.

Our plan is required to give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services.

If providers in the plan's network for a specialty are not available, it is the plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you will only pay in-network cost sharing. If you find yourself in a situation where there are no specialists in the plan's network that cover a service you need, call the plan for information on where to go to obtain this service at in-network cost sharing.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, seeing a women's health specialist, or finding a network specialist, please call to file a grievance with our Civil Rights Coordinator (contact information can be found in Chapter 9, Section 5). You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights, 1-800-368-1019 or TTY 1-800-537-7697.

Sección 1.1 Debemos proveer la información en una forma que le resulte conveniente y sea compatible con sus particularidades culturales (en idiomas diferentes del inglés, en braille, en letra grande, otros formatos alternativos, etc.)

Su plan debe garantizar que todos los servicios, tanto clínicos como no clínicos, se brinden de una manera culturalmente competente y sean accesibles para todos los afiliados, incluidos aquellos con dominio limitado del inglés, habilidades limitadas de lectura, discapacidad auditiva o aquellos de diverso origen cultural o étnico. Los ejemplos de cómo un plan puede cumplir con estos requisitos de accesibilidad incluyen, entre otros, la provisión de servicios de traducción, servicios de interpretación, teletipos o conexión TTY (teléfono de texto o teletipo).

Nuestro plan tiene servicios de interpretación gratuitos disponibles para responder a las preguntas de los miembros que no hablan inglés. Si lo necesita, también podemos proporcionarle información en braille, español, con letra grande o en otros formatos alternativos sin costo para usted. Debemos proporcionarle información sobre los beneficios del plan en un formato que le resulte accesible y apropiado. Para obtener información de nosotros de una manera que funcione para usted, llame a Servicios para Miembros.

Se requiere que nuestro plan brinde a las mujeres inscritas la opción de acceso directo a un especialista en salud de la mujer dentro de la red para los servicios de atención médica preventiva y de rutina de la mujer.

Si los proveedores de la red del plan para una especialidad no están disponibles, es responsabilidad del plan ubicar proveedores especializados fuera de la red que le brindarán la atención necesaria. En este caso, solo pagará el costo compartido dentro de la red. Si se encuentra en una situación donde no hay especialistas en la red del plan que cubran un servicio que necesita, llame al plan para obtener información sobre dónde ir para obtener este servicio con costos compartidos dentro de la red.

Si tiene inconvenientes para obtener información de nuestro plan en un formato que le resulte accesible y apropiado, para ver a un especialista en la salud de la mujer o para encontrar a un especialista de la red, llame para presentar una queja ante nuestro Coordinador de Derechos Civiles (puede encontrar la información de contacto en el Capítulo 9, Sección 5). También puede presentar un reclamo ante Medicare si llama al 1-800-MEDICARE (1-800-633-4227) o directamente en la Oficina de Derechos Civiles, al 1-800-368-1019 o TTY 1-800-537-7697.

Section 1.2 We must ensure that you get timely access to your covered services

You have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

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.

We will provide coverage for you if you are receiving active treatment using prior authorization. Coverage will include at a minimum a) approval of a prior authorization request for treatment, and must be valid for as long as medically necessary to avoid disruptions in care, in accordance with applicable coverage criteria, your individual medical history, and the treating provider's recommendation; and b) a minimum 90-day transition period for any active course(s) of treatment when you are enrolled in the Plan after starting a course of treatment, even if the service is provided by an out-of-network provider. This includes members new to the Plan. We must not disrupt or require reauthorization for an active course of treatment for new members for a period of at least 90 days.

If you think that you are not getting your medical care within a reasonable amount of time, Chapter 7 tells what you can do.

Section 1.3 We must protect the privacy of your personal health information

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.
- You have rights related to your 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.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.

- Except for the circumstances noted below, if we intend to 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 or someone you have given legal power to make decisions for you first.*
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
 - 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. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

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 healthcare 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 Member Services.

Section 1.4 We must give you information about the plan, its network of providers, and your covered services

As a member of Tufts Medicare Preferred HMO Basic No Rx, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call Member Services:

- **Information about our plan.** This includes, for example, information about the plan's financial condition.
- **Information about our network providers.** You have the right to get information about the qualifications of the providers in our network and how we pay the providers in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services.

- **Information about why something is not covered and what you can do about it.** Chapter 7 provides information on asking for a written explanation on why a medical service is not covered or if your coverage is restricted. Chapter 7 also provides information on asking us to change a decision, also called an appeal.

Section 1.5 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. 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.** 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.
- **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. Of course, if you refuse treatment, you accept full responsibility for what happens to your body as a result.

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 of 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.** You can get an advance directive 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. You can also contact Member Services to ask for the forms.
- **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. 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.**

- The hospital 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 Acentra Health (Massachusetts's Quality Improvement Organization) at 1-888-319-8452 (TTY: 711).

<p>Section 1.6 You have the right to make complaints and to ask us to reconsider decisions we have made</p>

If you have any problems, concerns, or complaints and need to request coverage, or make an appeal, Chapter 7 of this document tells what you can do. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

Section 1.7 What can you do if you believe you are being treated unfairly or your rights are not being respected?

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, sexual orientation, 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 Member Services**.
- You can **call the SHIP**. For details, 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 1.8 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can **call Member Services**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- You can contact **Medicare**.
 - You can visit the Medicare website to read or download the publication *Medicare Rights & Protections*. (The publication is available at: www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
 - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

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

Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Services.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* document 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.
- **If you have any other health insurance coverage in addition to our plan, or separate prescription drug coverage, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **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.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
 - To help get the best care, tell your doctors and other health providers about your health problems. 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 and get an answer you can understand.
- **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:
 - You must pay your plan premiums.
 - You must continue to pay your premium for your Medicare Part B to remain a member of the plan.
 - For some of your medical services covered by the plan, you must pay your share of the cost when you get the service.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* of our plan service area, you cannot remain a member of our plan.**
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

CHAPTER 7:

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

SECTION 1 Introduction

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

This chapter explains two types of processes for handling problems and concerns:

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**; also called grievances.

Both of these processes have been approved by Medicare. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

The guide in Section 3 will help you identify the right process to use and what you should do.

Section 1.2 What about the legal terms?

There are 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 make things easier, this chapter:

- Uses 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, 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. Knowing which terms to use will help you communicate more accurately to 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 Where to get more information and personalized assistance

We are always available to help you. Even if you have a complaint about our treatment of you, we are obligated to honor your right to complain. Therefore, you should always reach out to Member Services for help. But in some situations, you may also want help or guidance from someone who is not connected with us. **Below are two entities that can assist you.**

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. 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 and website URLs in Chapter 2, Section 3 of this document.

Medicare

You can also contact Medicare to get help. To contact 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 also visit the Medicare website (www.medicare.gov).

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

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

Is your problem or concern about your benefits or coverage?

This includes problems about whether medical care (medical items, services and/or Part B prescription drugs) are covered or not, the way they are covered, and problems related to payment for medical care or prescription drugs.

Yes.

Go on to the next section of this chapter, **Section 4, A guide to the basics of coverage decisions and appeals.**

No.

Skip ahead to **Section 9** at the end of this chapter: **How to make a complaint about quality of care, waiting times, customer service or other concerns.**

COVERAGE DECISIONS AND APPEALS

SECTION 4 A guide to the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals: the big picture

Coverage decisions and appeals deal with problems related to your benefits and coverage for medical care (services, items, and Part B prescription drugs, including payment). To keep things simple, we generally refer to medical items, services and Medicare Part B prescription drugs as **medical care**. You use the coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions prior to receiving benefits

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 example, if your plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either your network doctor can show that you received a standard denial notice for this medical specialist, or the *Evidence of Coverage* makes it clear that the referred service is never covered under any condition. 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 that you think you need. In other words, if you want to know if we will cover a medical care before you receive it, you can ask us to make a coverage decision for you. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide medical care 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, whether before or after a benefit is received, and you are not satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, which we discuss later,

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

you can request an expedited or **fast appeal** of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we were properly following the rules. When we have completed the review, we give you our decision.

In limited circumstances a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we say no to all or part of your Level 1 appeal for medical care, your appeal will automatically go on to a Level 2 appeal conducted by an independent review organization that is not connected to us.

- You do not need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we do not fully agree with your Level 1 appeal.
- See **Section 5.4** of this chapter for more information about Level 2 appeals.

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 8 in this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Member Services**.
- You **can get free help** from your SHIP.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Please call Member Services and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.thpmp.org.)
 - For medical care or Part B prescription drugs, 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.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- **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.
 - If you want a friend, relative, or another person to be your representative, call Member Services and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.thpmp.org.) 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.
 - While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form before 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 to dismiss your appeal.
- **You also have the right to hire a lawyer.** 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 4.3 Which section of this chapter gives the details for your situation?

There are three 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 5 of this chapter: Your medical care: How to ask for a coverage decision or make an appeal

Section 6 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 7 of this chapter: How to ask us to keep covering certain medical services if you think your coverage is ending too soon (*Applies to only these services*: 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 Member Services. You can also get help or information from government organizations such as your SHIP.

SECTION 5 Your medical care: How to ask for a coverage decision or make an appeal of a coverage decision

Section 5.1 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 our share of the cost of your care

This section is about your benefits for medical care. These benefits are described in Chapter 4 of this document: *Medical Benefits Chart (what is covered and what you pay)*. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

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. **Ask for a coverage decision. Section 5.2**
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. **Ask for a coverage decision. Section 5.2.**
3. You have received medical care that you believe should be covered by the plan, but we have said we will not pay for this care. **Make an appeal. Section 5.3.**
4. You have received and paid for medical care that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5.**
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. **Make an appeal. Section 5.3.**

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 Sections 6 and 7 of this Chapter. Special rules apply to these types of care.

Section 5.2 Step-by-step: How to ask for a coverage decision

Legal Terms

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

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

Step 1: Decide if you need a standard coverage decision or a fast coverage decision.

A standard coverage decision is usually made within 14 calendar days or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours for medical services, or 24 hours for Part B drugs. In order to get a fast coverage decision, you must meet two requirements:

- You may *only ask* for coverage for medical care items and/or services (not requests for payment for items and/or services 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 do not approve a fast coverage decision, we will send you a letter that:
 - Explains that we will use the standard deadlines.
 - Explains if your doctor asks for the fast coverage decision, we will automatically give you a fast coverage decision.
 - Explains that you can file a *fast complaint* about our decision to give you a standard coverage decision instead of the fast coverage decision you requested.

Step 2: Ask our plan to make a coverage decision or fast coverage decision.

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. Chapter 2 has contact information.

Step 3: We consider your request for medical care coverage and give you our answer.

For standard coverage decisions, we use the standard deadlines.

This means we will give you an answer within 14 calendar days after we receive your request **for a medical item or service**. If your request is for a **Medicare Part B prescription drug**, we will give you an answer **within 72 hours** after we receive your request.

- **However**, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a *fast complaint*. We will give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. See Section 9 of this chapter for information on complaints.)

For fast coverage decisions, we use an expedited timeframe.

A fast coverage decision means we will answer within 72 hours if your request is for a medical item or service. If your request is for a Medicare Part B prescription drug, we will answer within 24 hours.

- **However**, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days**. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a *fast complaint*. (See Section 9 of this chapter for information on complaints.) We will call you as soon as we make the decision.
- **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 4: If we say no to your request for coverage for medical care, you can appeal.

If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the medical care coverage you want. If you make an appeal, it means you are going on to Level 1 of the appeals process.

Section 5.3 Step-by-step: How to make a Level 1 appeal

Legal Terms

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

A *fast appeal* is also called an **expedited reconsideration**.

Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal is usually made within 30 calendar days or 7 calendar days for Part B drugs. A fast appeal is generally made within 72 hours.

- If you are appealing a decision we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a *fast appeal*. If your doctor tells us that your health requires a *fast appeal*, we will give you a fast appeal.
- The requirements for getting a *fast appeal* are the same as those for getting a *fast coverage decision* in Section 5.2 of this chapter.

Step 2: Ask our plan for an Appeal or a Fast Appeal

If you are asking for a standard appeal, submit your standard appeal in writing. Chapter 2 has contact information.

If you are asking for a fast appeal, make your appeal in writing or call us. Chapter 2 has contact information.

You must make your appeal request within 65 calendar days from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include 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. You and your doctor may add more information to support your appeal.

Step 3: We consider your appeal and we give you our answer.

When our plan is reviewing your appeal, we take a careful look at all of the information. We check to see if we were following all the rules when we said no to your request.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

We will gather more information if needed, possibly contacting you or your doctor.

Deadlines for a fast appeal

- For fast appeals, 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.
 - However, if you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time if your request is for a Medicare Part B prescription drug.
 - 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 review organization. Section 5.4 explains the Level 2 appeal 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 our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it receives your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. 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 more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
 - If you believe we should *not* take extra days, you can file a *fast complaint*. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (See Section 9 of this chapter for information on complaints.)
 - If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage within **30 calendar days** if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug.

- **If our plan says no to part or all of your appeal**, we will automatically send your appeal to the independent review organization for a Level 2 appeal.

Section 5.4 Step-by-step: How a Level 2 appeal is done

Legal Terms

The formal name for the *independent review organization* is the **Independent Review Entity**. It is sometimes called the **IRE**.

The **independent review organization** is an independent organization hired by Medicare. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: The Independent Review Organization reviews your appeal.

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

For the *fast appeal* the review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it receives your appeal.

However, if your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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

For the *standard appeal* if your request is for a medical item or service, the review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it receives your appeal. If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it receives your appeal.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- However, if your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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 a request for a medical item or service, 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 for standard requests. For expedited requests, we have 72 hours from the date we receive the decision from the review organization.

If the review organization says yes to part or all of a request for a Medicare Part B prescription drug, we must authorize or provide the Part B prescription drug within **72 hours** after we receive the decision from the review organization for **standard requests**. For **expedited requests**, we have **24 hours** from the date 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 us that your request (or part of your request) for coverage for medical care should not be approved. (This is called *upholding the decision or turning down your appeal*.) In this case, the independent review organization will send you a letter:

- Explaining its decision.
- Notifying you of the right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
- Telling you how to file a Level 3 appeal.

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 you want to go to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal.

The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter explains the Level 3, 4, and 5 appeals processes.

Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?

Chapter 5 describes when you may need to ask for reimbursement or ask us 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 asking for reimbursement, you are asking for a coverage decision. To make this decision, we will check to see if the medical care you paid for is covered. We will also check to see if you followed all the rules for using your coverage for medical care.

- **If we say yes to your request:** If the medical care is covered and you followed all the rules, we will send you the payment the cost typically within 30 calendar days, but no later than 60 calendar days, after we receive your request. If you haven't paid for the medical care, we will send the payment directly to the provider.
- **If we say no to your request:** 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 medical care and the reasons why.

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 Section 5.3. For appeals concerning reimbursement, please note:

- 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, you are not allowed to ask for a fast appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment 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 6 How to ask us to cover a longer inpatient hospital stay if you think you are being discharged 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.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

During your covered 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 help arrange for care you may need after you leave.

- The day you leave the hospital is called your **discharge date**.
- When your discharge date is decided, your doctor or the hospital staff will tell you.
- 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.

Section 6.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

Within two calendar days of being admitted to the hospital, 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. If you do not get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, please call Member Services or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

- 1. Read this notice carefully and ask questions if you don't understand it.** It tells you about:
 - 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.
 - Where to report any concerns you have about the quality of your hospital care.
 - Your right to **request an immediate review** of the decision to discharge you if you think you are being discharged from the hospital too soon. This 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.
- 2. You will be asked to sign the written notice to show that you received it and understand your rights.**
 - You or someone who is acting on your behalf will be asked to sign the notice.
 - Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date. Signing the notice **does not mean** you are agreeing on a discharge date.

3. Keep your copy of the notice handy so you will have the information about making an appeal (or reporting a concern about quality of care) if you need it.

- If you sign the notice more than two calendar days before your discharge date, 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 Member Services 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 the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html.

Section 6.2 Step-by-step: How to make a Level 1 appeal to change your hospital discharge date

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.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services. Or call your SHIP, a government organization that provides personalized assistance.

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.

The **Quality Improvement Organization** is a group of doctors and other health care professionals paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts are not part of our plan.

Step 1: Contact the Quality Improvement Organization for your state and ask for an immediate review of your hospital discharge. You must act quickly.

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.)

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge**.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- **If you meet this deadline**, you may stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
- **If you do *not* meet this deadline**, contact us. If 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.

Once you request an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted, we will give you a **Detailed Notice of Discharge**. This notice 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.

You can get a sample of the **Detailed Notice of Discharge** by calling Member Services 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 www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

- Health professionals at the Quality Improvement Organization (the *reviewers*) 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 told us of your appeal, you will get a written notice from us that gives your planned discharge date. This notice also 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.

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*, **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.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

What happens if the answer is no?

- If the review organization says *no*, 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 said no to 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 6.3 Step-by-step: How to make a Level 2 appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at their decision 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.

Step 1: Contact the Quality Improvement Organization again and ask for another review

You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you stay 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 of receipt of your request for a Level 2 appeal, the 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

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

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. This is called *upholding the decision*.

The notice you get will tell you in writing what you can do if you wish to continue with the review process.

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 you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.

The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 7.1 *This section is only about three services:*
Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

When you are getting covered **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

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 our share of the cost 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 7.2 We will tell you in advance when your coverage will be ending

Legal Term

Notice of Medicare Non-Coverage. It tells you 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.

1. **You receive a notice in writing** at least two calendar days before our plan is going to stop covering your care. The notice tells you:
 - The date when we will stop covering the care for you.
 - How to request a *fast track appeal* to request us to keep covering your care for a longer period of time.
2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you received it.** 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's decision to stop care.

Section 7.3 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.

Meet the deadlines.

Ask for help if you need it. If you have questions or need help at any time, please call Member Services. Or call your SHIP, a government organization that provides personalized assistance.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate.

The **Quality Improvement Organization** is a group of doctors and other health care experts paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts are not part of our plan.

Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization for your state and ask for a fast-track appeal. You must act quickly.***How can you contact this organization?***

The written notice you received (*Notice of Medicare Non-Coverage*) 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.)

Act quickly:

You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the Notice of Medicare Non-Coverage. If you miss the deadline, and you wish to file an appeal, you still have appeal rights. Contact your Quality Improvement Organization.

If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see Section 7.4.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

Legal Term
Detailed Explanation of Non-Coverage. Notice that provides details on reasons for ending coverage.

What happens during this review?

Health professionals at the Quality Improvement Organization (the *reviewers*) 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 tell us of your appeal, you will get the **Detailed Explanation of Non-Coverage** from us that explains in detail our reasons for ending our coverage for your services.

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?

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). There may be limitations on your covered services.

What happens if the reviewers say no?

If the reviewers say *no*, then **your coverage will end on the date we have told you.**

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.

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 a Level 2 appeal.

Section 7.4 Step-by-step: How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision 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.

Step 1: 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 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 calendar days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes?

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 made to your Level 1 appeal.

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 an Administrative Law Judge or attorney adjudicator.

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 you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.

The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 Taking your appeal to Level 3 and beyond

Section 8.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

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. The written response you receive to your Level 2 appeal will explain how to make 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.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Level 3 appeal **An Administrative Law Judge or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may* or *may not* be over.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that is favorable to you. If we decide to appeal, it will go to a Level 4 appeal.
 - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator'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 medical care in dispute.
- **If the Administrative Law Judge or attorney adjudicator 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. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal The **Medicare Appeals Council (Council)** will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may* or *may not* be over.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We will decide whether to appeal this decision to Level 5.
 - If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after receiving the 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 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.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the 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 and how to continue with a Level 5 appeal.

Level 5 appeal A judge at the **Federal District Court** will review your appeal.

A judge will review all of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

MAKING COMPLAINTS

SECTION 9 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 9.1 What kinds of problems are handled by the complaint process?

The complaint process is *only* used for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service. Here are examples of the kinds of problems handled by the complaint process.

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"> • Did someone not respect your right to privacy or share confidential information?
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 our Member Services? • 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?

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Complaint	Example
	<ul style="list-style-type: none"> • Have you been kept waiting too long by doctors or other health professionals? Or by our Member Services or other staff at the plan? <ul style="list-style-type: none"> ◦ Examples include waiting too long on the phone, in the waiting or 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"> • Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all related to the <i>timeliness</i> of our actions related to coverage decisions and appeals)	<p>If you have asked 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"> • You asked us for a <i>fast coverage decision</i> or a <i>fast appeal</i>, and we have said no; you can make a complaint. • You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we are not meeting deadlines for covering or reimbursing you for certain medical items or services that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 9.2 How to make a complaint

Legal Terms

- A **Complaint** is also called a **grievance**.
- **Making a complaint** is also called **filing a grievance**.
- **Using the process for complaints** is also called **using the process for filing a grievance**.
- A **fast complaint** is also called an **expedited grievance**.

Section 9.3 Step-by-step: Making a complaint

Step 1: Contact us promptly – either by phone or in writing.

Usually, calling Member Services is the first step. If there is anything else you need to do, Member Services will let you know.

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 Member Services. You can also file a grievance in writing by sending it by mail to: Tufts Health Plan, Attn: Appeals & Grievances, P.O. Box 474, Canton, MA 02021. You can also send it in writing via fax at: 1-617-972-9516. If you want a friend, relative, or other person to be your representative, call Member Services and ask for the *Centers for Medicare & Medicaid Appointment of Representative* form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.thpmp.org.) 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.

The **deadline** for making a complaint is **60 calendar days** from the time you had the problem you want to complain about.

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.

Most complaints are answered within 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

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.

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**.

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 include our reasons in our response to you.

Section 9.4 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization.** 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. Chapter 2 has contact information.

Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time.**

Section 9.5 You can also tell Medicare about your complaint

You can submit a complaint about Tufts Medicare Preferred HMO Basic No Rx directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 8:

*Ending your membership in the
plan*

SECTION 1 Introduction to ending your membership in our plan

Ending your membership in Tufts Medicare Preferred HMO Basic No Rx 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. Sections 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where 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, our plan must continue to provide your medical care and you will continue to pay your cost share until your membership ends.

SECTION 2 When can you end your membership in our plan?

Section 2.1 You can end your membership during the Annual Enrollment Period

You can end your membership during the **Annual Enrollment Period** (also known as the *Annual Open Enrollment Period*). During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- The **Annual Enrollment Period** is from **October 15 to December 7**.
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of plans:
 - Another Medicare health plan, with or without prescription drug coverage,
 - Original Medicare *with* a separate Medicare prescription drug plan,
 - – *or* – Original Medicare *without* a separate Medicare prescription drug plan.
- **Your membership will end in our plan** when your new plan's coverage begins on January 1.

Section 2.2 You can end your membership during the Medicare Advantage Open Enrollment Period

You have the opportunity to make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period**.

- **The annual Medicare Advantage Open Enrollment Period** is from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in an MA plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement.
- **During the annual Medicare Advantage Open Enrollment Period**, you can:
 - Switch to another Medicare Advantage Plan with or without prescription drug coverage.
 - Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of Tufts Medicare Preferred HMO Basic No Rx may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply to you. These are just examples; for the full list, you can contact the plan, call Medicare, or visit the Medicare website (www.medicare.gov):

- Usually, when you have moved.
- If you have Medicaid (MassHealth).
- If we violate our contract with you.
- If you get care in an institution, such as a nursing home or long-term care (LTC) hospital.
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE).

The enrollment time periods vary depending on your situation.

To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:

- Another Medicare health plan with or without prescription drug coverage.
- Original Medicare *with* a separate Medicare prescription drug plan.

- – *or* – Original Medicare *without* a separate Medicare prescription drug plan.

Your membership will usually end on the first day of the month after your request to change your plan is received.

Section 2.4 Where can you get more information about when you can end your membership?

If you have any questions about ending your membership you can:

- **Call Member Services.**
- Find the information in the *Medicare & You 2025* handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

SECTION 3 How do you end your membership in our plan?

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 Medicare Preferred HMO Basic No Rx 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 Medicare Preferred HMO Basic No Rx when your new plan's coverage begins.

If you would like to switch from our plan to:	This is what you should do:
<ul style="list-style-type: none">• Original Medicare <i>without</i> a separate Medicare prescription drug plan.	<ul style="list-style-type: none">• Send us a written request to disenroll. Contact Member Services if you need more information on how to do this.• 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 Medicare Preferred HMO Basic No Rx when your coverage in Original Medicare begins.

Note: If you also have creditable prescription drug coverage (e.g., standalone PDP) and disenroll from that coverage, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later after going without creditable prescription drug coverage for 63 days or more in a row.

SECTION 4 Until your membership ends, you must keep getting your medical items, services through our plan

Until your membership ends, and your new Medicare coverage begins, you must continue to get your medical items, services through our plan.

- **Continue to use our network providers to receive medical care.**
- **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 Medicare Preferred HMO Basic No Rx must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

Tufts Medicare Preferred HMO Basic No Rx must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.

- 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 Member Services to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you are no longer a United States citizen or lawfully present in the United States.
- 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 do not pay the plan premiums for *2 months*.
 - We must notify you in writing that you have *2 months* to pay the plan premium before we end your membership.

Where can you get more information?

If you have questions or would like more information on when we can end your membership, call Member Services.

Section 5.2 We <u>cannot</u> ask you to leave our plan for any health-related reason

Tufts Medicare Preferred HMO Basic No Rx is not allowed to ask you to leave our plan for any health-related reason.

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, call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

Section 5.3 You have the right to make a complaint if we end your membership in our plan

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 file a grievance or make a complaint about our decision to end your membership.

CHAPTER 9:

Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* 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. This may affect your rights and responsibilities even if the laws are not included or explained in this document.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. 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, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

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** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at <https://www.hhs.gov/ocr/index.html>.

If you have a disability and need help with access to care, please call us at Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

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 Medicare Preferred HMO Basic No Rx, 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 Medicare Preferred HMO Basic No Rx and providers

Tufts Medicare Preferred HMO Basic No Rx provides coverage for health care services. Tufts Medicare Preferred HMO Basic No Rx does not provide health care services. Tufts Medicare Preferred HMO Basic No Rx has contractual agreements with providers practicing in facilities and private offices throughout the service area. These providers are independent. They are not Tufts Medicare Preferred HMO Basic No Rx employees, or representatives. Providers are not authorized to change this *Evidence of Coverage* or assume or create any obligation for Tufts Medicare Preferred HMO Basic No Rx that is inconsistent with this *Evidence of Coverage*.

SECTION 5 Notice about Section 1557 of the Affordable Care Act

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

Tufts Health Plan:

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

If you need these services, contact Tufts Health Plan at 1-800-701-9000 (TTY 711).

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

Tufts Health Plan, Attention:

Civil Rights Coordinator, Legal Dept.

1 Wellness Way

Canton, MA 02021

Phone: 1-888-880-8699 ext. 48000

TTY number: 1-800-439-2370 or 711

Español: 1-866-930-9252

Fax: 1-617-972-9048

Email: OCRCoordinator@point32health.org

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

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

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building,

Washington, DC 20201

1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at <https://www.hhs.gov/ocr/office/file/index.html>.

CHAPTER 10:

Definitions of important words

Chapter 10. 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.

Annual Enrollment Period – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or payment for services you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of Tufts Medicare Preferred HMO Basic No Rx, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to *balance bill* or otherwise charge you more than the amount of cost-sharing your plan says you must pay.

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 have not 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.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare.

Chronic-Care Special Needs Plan – C-SNPs are SNPs that restrict enrollment to MA eligible individuals who have one or more severe or disabling chronic conditions, as defined under 42 CFR 422.2, including restricting enrollment based on the multiple commonly co-morbid and clinically linked condition groupings specified in 42 CFR 422.4(a)(1)(iv).

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example, 20%) as your share of the cost for services.

Complaint – The formal name for *making a complaint* is *filing a grievance*. The complaint process is used *only* for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment (or copay) – 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. A copayment is a set amount (for example, \$10), rather than a percentage.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services are received. (This is in addition to the plan’s monthly premium.) Cost sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services are covered; (2) any fixed *copayment* amount that a plan requires when a specific service is received; or (3) any *coinsurance* amount, a percentage of the total amount paid for a service, that a plan requires when a specific service is received.

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, provided by people who do not have professional skills or training, includes 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.

Deductible – The amount you must pay for health care before our plan pays.

Disenroll or Disenrollment – The process of ending your membership in our plan.

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll individuals who are entitled to both Medicare (Title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (Title XIX). States cover some Medicare costs, depending on the state and the individual’s eligibility.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

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 (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment

to a bodily function. 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) provided 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.

Grievance – A type of complaint you make about our plan or providers, including a complaint concerning the quality of your care. This does not involve coverage or payment disputes.

Home Health Aide – A person who provides services that do not 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).

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. 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.

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*.

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. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins three months before the month you turn 65, includes the month you turn 65, and ends three months after the month you turn 65.

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for in-network covered services. Amounts you pay for your plan premiums and Medicare Part A and Part B premiums do not count toward the maximum out-of-pocket amount. In addition to the maximum out-of-pocket amount for in-network covered medical services, we also have a maximum out-of-pocket amount for certain types of services.

Medicaid (or Medical Assistance) – A joint Federal and State program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

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).

Medicare Advantage Open Enrollment Period – The time period from January 1 to March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan or obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after an individual is first eligible for Medicare.

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 i) an HMO, ii) a PPO, a iii) a Private Fee-for-Service (PFFS) plan, or iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). 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**. Tufts Medicare Preferred HMO Basic No Rx does not offer Medicare prescription drug coverage.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all of the services that are covered by Medicare Part A and B. The term Medicare-Covered Services does not include the extra benefits, such as vision, dental or hearing, that a Medicare Advantage plan may offer.

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, Special Needs 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).

Member Services – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

Network Provider – Provider is the general term 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. **Network providers** 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. Network providers are also called *plan providers*.

Observation – Observation services are hospital outpatient services given to help the doctor decide if the patient needs to be admitted as an inpatient or can be discharged. Observation services may be given in the Emergency Department (ED) or another area of the hospital.

Optional Supplemental Benefits – Non-Medicare-covered benefits that can be purchased for an additional premium and are not included in your package of benefits. You must voluntarily elect Optional Supplemental Benefits in order to get them.

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called *coverage decisions* in this document.

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 Provider or Out-of-Network Facility – A provider or facility that does not have a contract with our plan 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.

Out-of-Pocket Costs – See the definition for *cost sharing* above. A member's cost sharing requirement to pay for a portion of services received is also referred to as the member's *out-of-pocket* cost requirement.

PACE Plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term services and supports (LTSS) for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

Part C – see Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

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 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 Provider (PCP) – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization – Approval in advance to get services. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4.

Prosthetics and Orthotics – Medical devices including, but not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

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.

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 Medicare Preferred 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 you must live to join a particular health plan. 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 must 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 care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you move into a nursing home, or if we violate our contract with you.

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 Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

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 Services – A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service if either you are temporarily outside the service area of the plan, or it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable.



Tufts Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

Tufts Health Plan:

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

If you need these services, contact Tufts Health Plan at
1-800-701-9000 (HMO)/1-866-623-0172 (PPO)/(TTY: 711).

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

Tufts Health Plan, Attention:
Civil Rights Coordinator, Legal Dept.
1 Wellness Way, Canton, MA 02021
Phone: 1-888-880-8699 ext. 48000, (TTY: 711)
Fax: 1-617-972-9048
Email: OCRCoordinator@point32health.org

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

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

U.S. Department of Health and Human Services

200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201
1-800-368-1019 (TDD: 1-800-537-7697)

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

thpmp.org | 1-800-701-9000 (HMO)/1-866-623-0172 (PPO)/(TTY: 711)

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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 1-800-701-9000 (HMO)/1-866-623-0172 (PPO). 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 1-800-701-9000 (HMO)/1-866-623-0172 (PPO). 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 1-800-701-9000 (HMO)/1-866-623-0172 (PPO)。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 1-800-701-9000 (HMO)/1-866-623-0172 (PPO)。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 1-800-701-9000 (HMO)/1-866-623-0172 (PPO). 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 1-800-701-9000 (HMO)/1-866-623-0172 (PPO). 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 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) 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 1-800-701-9000 (HMO)/1-866-623-0172 (PPO). 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 1-800-701-9000 (HMO)/1-866-623-0172 (PPO)번으로 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 1-800-701-9000 (HMO)/1-866-623-0172 (PPO). 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 مترجم فوري، سيقوم شخص ما يتحدث العربية (PPO) 1-800-701-9000 (HMO)/1-866-623-0172 ليس عليك سوى الاتصال بنا على بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे द्वारा दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुद्दु भाषिया सेवाएँ उपलब्ध हैं। एक दुभाषिया परामर्श के लिए, बस हमें 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) पर फोन करें। कोई भी हिंदी 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 1-800-701-9000 (HMO)/1-866-623-0172 (PPO). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Português: 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 1-800-701-9000 (HMO)/1-866-623-0172 (PPO). 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 1-800-701-9000 (HMO)/1-866-623-0172 (PPO). 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 1-800-701-9000 (HMO)/1-866-623-0172 (PPO). 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、1-800-701-9000 (HMO)/1-866-623-0172 (PPO)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。

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Method	Member Services—Contact Information
CALL	1-800-701-9000 Calls to this number are free. Representatives are available 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31 and Monday–Friday from April 1 to September 30. After hours and on holidays, please leave a message and a representative will return your call on the next business day. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 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 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31 and Monday–Friday from April 1 to September 30. After hours and on holidays, please leave a message and a representative will return your call on the next business day.
FAX	1-617-972-9405
WRITE	Tufts Medicare Preferred ATTN: Member Services P.O. Box 494 Canton, MA02021
WEBSITE	www.thpmp.org

SHINE (Serving the Health Insurance Needs of Everyone)(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.

Method	Contact Information
CALL	1-800-243-4636
TTY	1-800-439-2370 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/health-insurance-counseling



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