January 1 – December 31, 2027

Evidence of Coverage for 2027

Your Medicare Health Benefits and Services as a Member of: Tufts Medicare Preferred HMO Prime No Rx (HMO)

This document gives the details of your Medicare health coverage from January 1 – December 31, 2027. **This is an important legal document. Keep it in a safe place.**

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

- Your plan premium and cost sharing
- Your medical benefits
- How to file a complaint if you're not satisfied with a service or treatment
- How to contact us
- Other protections required by Medicare law

For questions about this document, call Member Services at 1-800-701-9000 (TTY users 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 Prime No Rx (HMO), 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 Prime No Rx (HMO).)

This document is available for free in Spanish.

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

Benefits, premiums, copayments/coinsurance may change on January 1, 2028.

Our formulary, pharmacy network, and/or provider network may change at any time. You'll get notice about any changes that may affect you at least 30 days in advance.

OMB Approval 0938-1051 (Expires: July 31, 2029)

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CHAPTER 1:

Get started as a member

SECTION 1 You're a member of Tufts Medicare Preferred HMO Prime No Rx (HMO)

Section 1.1 You're enrolled in Tufts Medicare Preferred HMO Prime No Rx (HMO), which is a Medicare HMO

You're covered by Medicare, and you chose to get your Medicare health coverage through our plan, Tufts Medicare Preferred HMO Prime No Rx (HMO). Our plan covers all Part A and Part B services. However, cost sharing and provider access in this plan are different from Original Medicare.

Tufts Medicare Preferred HMO Prime No Rx (HMO) 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 Prime No Rx (HMO) *doesn't* include Part D drug coverage.

Section 1.2 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how Tufts Medicare Preferred HMO Prime No Rx (HMO) covers your care. Other parts of this contract include your enrollment form and any notices you get 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 the months you're enrolled in Tufts Medicare Preferred HMO Prime No Rx (HMO) between January 1, 2027, and December 31, 2027.

Medicare allows us to make changes to plans we offer each calendar year. This means we can change the costs and benefits of Tufts Medicare Preferred HMO Prime No Rx (HMO) after December 31, 2027. We can also choose to stop offering our plan in your service area, after December 31, 2027.

Medicare (the Centers for Medicare & Medicaid Services) must approve Tufts Medicare Preferred HMO Prime No Rx (HMO) each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue offering our plan and Medicare renews approval of our plan.

SECTION 2 Plan eligibility requirements

Section 2.1 Eligibility requirements

You're eligible for membership in our plan as long as you meet all these conditions:

- You have both Medicare Part A and Medicare Part B
- You live in our geographic service area (described in Section 2.2). People who are incarcerated aren't considered to be living in the geographic service area, even if they're physically located in it
- You're a United States citizen or national, or an eligible noncitizen.

Section 2.2 Plan service area for Tufts Medicare Preferred HMO Prime No Rx (HMO)

Tufts Medicare Preferred HMO Prime No Rx (HMO) is only available to people who live in our plan service area. To stay a member of our plan, you must continue to live in our service area. The service area is described below.

Our service area includes these counties in Massachusetts:

- Barnstable County
- Bristol County
- Essex County
- Middlesex County
- Norfolk County
- Plymouth County
- Suffolk County
- Worcester County

If you move out of our plan's service area, you can't stay a member of this plan. Call Member Services at 1-800-701-9000 (TTY users call 711) to see if we have a plan in your new area. When you move, you'll have a Special Enrollment Period to either switch to Original Medicare or enroll in a Medicare health plan in your new location.

If you move or change your mailing address, it's also important to call Social Security. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

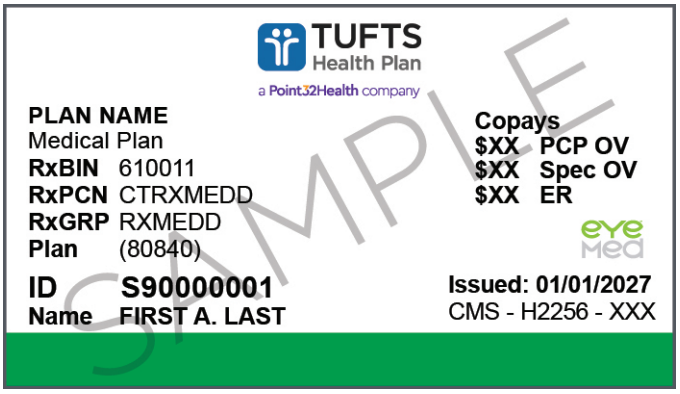
Section 2.3 U.S. citizen or national, or eligible noncitizen

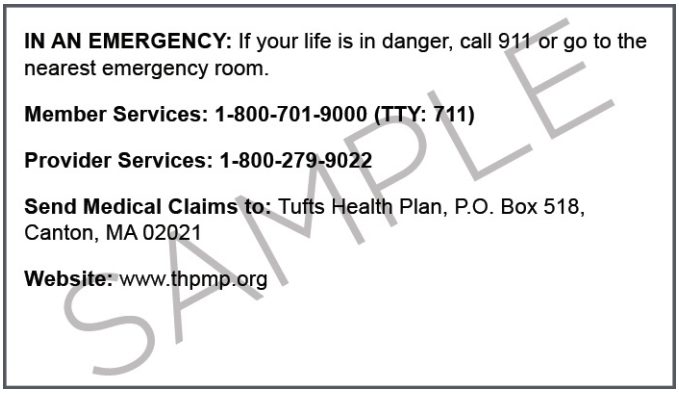
You must be a U.S. citizen or national, or an eligible noncitizen to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify Tufts Medicare Preferred HMO Prime No Rx (HMO) if you're not eligible to stay a member of our plan on this basis. Tufts Medicare Preferred HMO Prime No Rx (HMO) must disenroll you if you don't meet this requirement.

SECTION 3 Important membership material

Section 3.1 Our plan membership card

Use your membership card whenever you get services covered by our plan. You should also show the provider your Medicaid card, if you have one. Sample membership card:





DON'T use your red, white and blue Medicare card for covered medical services while you're a member of this plan. If you use your Medicare card instead of your Tufts Medicare Preferred HMO Prime No Rx (HMO) 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 at 1-800-701-9000 (TTY users call 711) right away and we'll send you a new card.

Section 3.2 Provider Directory

The *Provider Directory* thpmp.org/documents 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'll have to pay in full. The only exceptions are emergencies, urgently needed services when the network isn't available (that is, situations where it's unreasonable or not possible to get services in-network), out-of-area dialysis services, and cases when Tufts Medicare Preferred HMO Prime No Rx (HMO) authorizes use of out-of-network providers.

Get the most recent list of providers and suppliers on our website at thpmp.org.

If you don't have a *Provider Directory*, you can ask for a copy (electronically or in paper form) from Member Services at 1-800-701-9000 (TTY users call 711). Requested paper *Provider Directories* will be mailed to you within 3 business days.

SECTION 4 Summary of Important Costs for 2027

	Your Costs in 2027
Monthly plan premium* * Your premium can be higher or lower than this amount. Go to Section 4.1 for details.	**Go to Section 4.1 for details.**
Maximum out-of-pocket amount This is the most you'll pay out-of-pocket for covered services. (Go to Chapter 4 Section 1.2 for details.)	**$3,850**
Primary care office visits	**$10 copayment per visit**
Specialist office visits	**$20 copayment per visit**
Inpatient hospital stays Includes various inpatient hospital stays such as acute care rehabilitation and long-term care. An inpatient hospital stay starts the day you're formally admitted with a doctor's order and ends the day before you're discharged.	**$300 copayment for each Medicare-covered hospital stay up to $900 per year.** **Please see Chapter 4, Section 2 for cost sharing for Inpatient services in a psychiatric hospital.**

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)

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 Prime No Rx (HMO)
Barnstable County	$163
Bristol County	$163
Essex County	$186
Middlesex County	$163
Norfolk County	$163
Plymouth County	$163
Suffolk County	$186
Worcester County	$182

Medicare Part B premiums differ for people with different incomes. If you have questions about these premiums, check your copy of the *Medicare & You 2027* handbook, in the section called *2027 Medicare Costs*. Download a copy from the Medicare website (Medicare.gov/medicare-and-you) or order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), TTY users call 1-877-486-2048.

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 stay a member of our plan**. This includes your premium for Part B. You may also pay a premium for Part A, if you 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*, you pay an additional premium each month for these extra benefits. Go to Chapter 4, Section 2.1 for details. The additional monthly premium for adding the Tufts Medicare Preferred Dental Option to your plan is $38.50. If you have any questions about your plan premiums, please call Member Services.

SECTION 5 More information about your monthly plan premium

Section 5.1 How to pay your plan premium

There are 4 ways you can pay your plan premium.

Option 1: Pay by check

The monthly plan premium is due on the 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
P.O. 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: You can pay 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 day 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: You can pay online

You can pay your monthly plan premium online by signing up for a secure personal account on our website at thpmp.org/registration. (If you already have an account, just go to 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 plan 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 thpmp.org/registration.

Option 4: Have plan premiums deducted from your monthly Social Security check

Changing the way you pay your plan premium

If you decide to change how you pay your plan premium, it can take up to 3 months for your new payment method to take effect. While we process your new payment method, you're still responsible for making sure your plan premium is paid on time. To change your payment method, contact Member Services.

If you have trouble paying your plan premium

Your plan premium is due in our office by the 15th day of the month. If we don't get your payment by the 15th day of the month, we'll send you a notice letting you know your plan membership will end if we don't get your premium payment within 2 months.

If you have trouble paying your premium on time, call Member Services at 1-800-701-9000 (TTY users call 711) 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 premium, you'll have health coverage under Original Medicare.

At the time we end your membership, you may still owe us for unpaid premiums. We have the right to pursue collection of the amount you owe. If you want to enroll again in our plan (or another plan that we offer), you'll need to pay the late premiums before you can enroll.

If you think we wrongfully ended your membership, you can make a complaint (also called a grievance). If you had an emergency circumstance out of your control that made you unable to pay your premiums within our grace period, you can make a complaint. For complaints, we'll review our decision again. Go to Chapter 7 to learn how to make a complaint or call us at 1-800-701-9000 between 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 call 711. You must make your complaint no later than 60 calendar days after the date your membership ends.

Section 5.2 Your monthly plan premium won't change during the year

We're not allowed to change your plan's monthly plan premium amount during the year. If the monthly plan premium changes for next year, we'll tell you in September and the new premium will take effect on January 1.

SECTION 6 Keep your plan membership record up to date

Your membership record has information from your enrollment form, including your address and phone number. It shows your specific plan coverage including your Primary Care Provider, Medical Group, and IPA.

The doctors, hospitals, and other providers in your plan's network **use your membership record to know what services are covered and your cost-sharing amounts**. Because of this, it's very important to help us keep your information up to date.

If you have any of these changes, let us know:

- Changes to your name, address, or phone number
- Changes in any other health coverage you have (such as from your employer, your spouse or domestic partner's employer, workers' compensation, or Medicaid)
- Any liability claims, such as claims from an automobile accident
- If you're admitted to a nursing home
- If you get 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 participate in a clinical research study (**Note**: You're not required to tell our plan about clinical research studies you intend to participate in, but we encourage you to do so.)

If any of this information changes, let us know by calling Member Services at 1-800-701-9000 (TTY users call 711). 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 thpmp.org/registration.

It's also important to contact Social Security if you move or change your mailing address. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

SECTION 7 How other insurance works with our plan

Medicare requires us to collect information about any other medical or drug coverage you have so we can coordinate any other coverage with your benefits under our plan. This is called **Coordination of Benefits**.

Once a year, we'll send you a letter that lists any other medical or drug coverage we know about. Read this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that's not listed, call Member Services at 1-800-701-9000 (TTY users call 711). You may need to give our plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

When you have other insurance (like employer group health coverage), Medicare rules decide whether our plan or your other insurance pays first. The insurance that pays first ("the primary payer") pays up to the limits of its coverage. The insurance that pays second ("the secondary payer") only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay 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) are 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 has more than 100 employees.
    - If you're over 65 and you (or your spouse or domestic partner) are 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 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:

Phone numbers and resources

SECTION 1 Tufts Medicare Preferred HMO Prime No Rx (HMO) contacts

For help with claims, billing, or member card questions, call or write to Tufts Medicare Preferred HMO Prime No Rx (HMO) Member Services. We'll be happy to help you.

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 1-800-701-9000 (TTY users call 711) also has free language interpreter services for non-English speakers.
TTY	711 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, MA 02021
Website	thpmp.org

How to ask 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 pay for your medical services. For more information on how to ask for coverage decisions about your medical care, go to Chapter 7.

Coverage Decisions for Medical Care – 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 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, MA 02021
Website	thpmp.org

How to ask for an appeal about your medical care

An appeal is a formal way of asking us to review and change a coverage decision. For more information on how to ask for appeals about your medical care, go to Chapter 7.

Appeals for Medical Care – Contact Information	
Call	1-800-701-9000

Appeals for Medical Care – Contact Information	
	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 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	1-617-972-9516
Write	Tufts Medicare Preferred Attn: Appeals & Grievances P.O. Box 474 Canton, MA 02021
Website	thpmp.org

How to make 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 doesn't involve coverage or payment disputes. For more information on how to make a complaint about your medical care, go to Chapter 7.

Complaints about Medical Care – Contact Information	
Call	1-800-701-9000 Calls to this number are free.

Complaints about Medical Care – Contact Information	
	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 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	1-617-972-9516
Write	Tufts Medicare Preferred Attn: Appeals & Grievances P.O. Box 474 Canton, MA 02021
Medicare website	To submit a complaint about Tufts Medicare Preferred HMO Prime No Rx (HMO) directly to Medicare, go to Medicare.gov/my/medicare-complaint.

How to ask us to pay our share of the cost for medical care you got

If you got a bill or paid for services (like a provider bill) you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. Go to Chapter 5 for more information.

If you send us a payment request and we deny any part of your request, you can appeal our decision. Go to Chapter 7 for more information.

Payment Request – Contact Information	
Call	1-800-701-9000 Calls to this number are free.

Payment Request – Contact Information	
	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
Fax	1-617-972-1028
Write	Tufts Medicare Preferred P.O. Box 518 Canton, MA 02021
Website	thpmp.org

SECTION 2 Get help from Medicare

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 (CMS). This agency contracts with Medicare Advantage organizations including our plan.

Medicare – Contact Information	
Call	1-800-MEDICARE (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 hearing or speaking. Calls to this number are free.
Chat Live	Chat live at Medicare.gov/talk-to-someone.

Medicare – Contact Information	
Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044
Website	Medicare.gov • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. • Find Medicare-participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly "Wellness" visits). • Get Medicare appeals information and forms. • Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. • Look up helpful websites and phone numbers. You can also visit Medicare.gov to tell Medicare about any complaints you have about Tufts Medicare Preferred HMO Prime No Rx (HMO). **To submit a complaint to Medicare**, go to Medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

SECTION 3 State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. In Massachusetts, the SHIP is called SHINE (Serving the Health Insurance Needs of Everyone).

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

SHINE counselors can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and straighten out problems with your Medicare bills. SHINE counselors can

also help you with Medicare questions or problems, help you understand your Medicare plan choices and answer questions about switching plans.

	SHINE (Serving the Health Insurance Needs of Everyone) (Massachusetts' SHIP) – Contact Information
Call	1-800-243-4636 Representatives are available to help you Monday - Friday, 9:00 am - 5:00 pm.
TTY	1-800-439-2370 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
Write	Call the number above for the address of the SHINE program in your area.
Website	mass.gov/health-insurance-counseling

SECTION 4 Quality Improvement Organization (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare 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's not connected with our plan.

Contact Acentra Health in any of these situations:

- You have a complaint about the quality of care you got. Examples of quality-of-care concerns include getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis.
- 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 is ending too soon.

	Acentra Health (Massachusetts' Quality Improvement Organization) – Contact Information
Call	1-888-319-8452

	Acentra Health (Massachusetts' Quality Improvement Organization) – Contact Information
	9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays. 24-hour voicemail service is available. Translation services are available for beneficiaries and caregivers who do not speak English.
TTY	711
Write	Acentra Health 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317
Website	acentraqio.com

SECTION 5 Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment.

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

Social Security— Contact Information	
Call	1-800-772-1213 Calls to this number are free. Available 8 am to 7 pm, Monday through Friday. Use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8 am to 7 pm, Monday through Friday.
Website	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. Medicaid offers programs to 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 Medicare Savings Programs, contact MassHealth.

	MassHealth (Massachusetts' Medicaid Program) – Contact Information
Call	Customer Service: 1-800-841-2900 Enrollment: 1-877-623-6765 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
Write	MassHealth Central Office 100 Hancock Street, 1st Floor Quincy, MA 02171
Website	mass.gov/masshealth

SECTION 7 Railroad Retirement Board (RRB)

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 get Medicare through the Railroad Retirement Board, let them know if you move or change your mailing address. For questions about your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board (RRB) – Contact Information	
Call	1-877-772-5772 Calls to this number are free. Press “0” to speak with an RRB representative from 9 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9 am to 12 pm on Wednesday. Press “1” to access the automated RRB HelpLine and get recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number aren’t free.
Website	https://RRB.gov

SECTION 8 If 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, call the employer/union benefits administrator or Member Services at 1-800-701-9000 (TTY users call 711) with any questions. You can ask about your (or your spouse or domestic partner’s) employer or retiree health benefits, premiums, or the enrollment period. You can call 1-800-MEDICARE (1-800-633-4227) with questions about your Medicare coverage under this plan. TTY users call 1-877-486-2048.

CHAPTER 3:

Using our plan for your medical services

SECTION 1 How to get medical care as a member of our plan

This chapter explains what you need to know about using our plan to get your medical care covered.

For details on what medical care our plan covers and how much you pay when you get care, go to the Medical Benefits Chart in Chapter 4.

Section 1.1 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 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 Medical Benefits Chart in Chapter 4.

Section 1.2 Basic rules for your medical care to be covered by our plan

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

Tufts Medicare Preferred HMO Prime No Rx (HMO) will generally cover your medical care as long as:

- **The care you get is included in our plan’s Medical Benefits Chart** in Chapter 4.

- **The care you get 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) providing and overseeing your care.** As a member of our plan, you must choose a network PCP (go to Section 2.1 of this chapter for more information).
    - In most situations, your network PCP must give you approval in advance (a referral) before you can use other providers in our plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. For more information, go to Section 2.3.
    - You don't need referrals from your PCP for emergency care or urgently needed services. To learn about other kinds of care you can get without getting approval in advance from your PCP, go to Section 2.2.
- **You must get your care from a network provider** (go to Section 2). In most cases, care you get from an out-of-network provider (a provider who's not part of our plan's network) won't be covered. This means you have to pay the provider in full for services you get. *Here are 3 exceptions*:
    - Our plan covers emergency or urgently needed services you get from an out-of-network provider. For more information and to see what emergency or urgently needed services are, go to Section 3.
    - 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 pay the same as you pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, go to Section 2.4.
    - Our plan covers kidney dialysis services you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay our plan for dialysis can never be higher than the cost sharing in Original Medicare. If you're outside our plan's service area and get dialysis from a provider outside our plan's network, your cost sharing can't be higher than the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to get services inside our service area from a provider outside our plan's network, your cost sharing for the dialysis may be higher.

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

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

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

When you become a member of our plan, you must choose a 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 getting prior authorization, if applicable?

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 to choose a 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.

How to change your PCP

You can change your PCP for any reason, at any time. It's also possible that your PCP might leave our plan's network of providers, and you'd need to choose 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 thpmp.org/registration.

Section 2.2 Medical care you can get without a PCP referral

You can get the services listed below without getting approval in advance from your PCP:

- Routine women's health care, including 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, COVID-19 vaccines, Hepatitis B vaccines, and pneumonia vaccines 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 are services that require immediate medical attention (but not an emergency) if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area. If possible, call Member Services at 1-800-701-9000 (TTY users call 711) before you leave the service area so we can help arrange for you to have maintenance dialysis while you're 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. For example:

- 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 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. 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.

When a specialist or another network provider leaves our plan

We may make changes to the hospitals, doctors and specialists (providers) in our plan's network during the year. If your doctor or specialist leaves our plan, you have these rights and protections:

- Even though our network of providers may change during the year, Medicare requires that you have uninterrupted access to qualified doctors and specialists.
- We'll notify you that your provider is leaving our plan so that you have time to choose a new provider.
    - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past 3 years.

  - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them or visited them within the past 3 months.
- We'll help you choose a new qualified in-network provider for continued care.
- If you're undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- When an in-network provider or benefit is unavailable or inadequate to meet your medical needs, we'll arrange for any medically necessary covered benefit outside of our provider network at in-network cost sharing.
- If you find out your doctor or specialist is leaving our plan, call Member Services at 1-800-701-9000 (TTY users call 711) so we can help you choose a new provider to manage your care.
- If you believe we haven't furnished you with a qualified provider to replace your previous provider, or that your care isn't being appropriately managed, you have the right to file a quality-of-care complaint to the QIO, a quality-of-care grievance to our plan, or both. (Go to 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 in an emergency, disaster, or urgent need for care

Section 3.1 Get care if you have a medical 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're 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's 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 don't need to get approval or a referral first from your PCP. You don't need to use a network doctor. You can get covered emergency medical care whenever you need it, worldwide, and from any provider with an appropriate state license even if they're 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 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.

Covered services in 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 giving you emergency care will decide when your condition is stable, and when the medical emergency is over.

After the emergency is over, you're 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'll 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 wasn't an emergency, as long as you reasonably thought your health was in serious danger, we'll cover your care.

However, after the doctor says it wasn't an emergency, we'll cover additional care *only* if you get the additional care in one of these 2 ways:

- You go to a network provider to get the additional care.
- The additional care you get is considered urgently needed services and you follow the rules below for getting this urgent care.

Section 3.2 Get care when you have an urgent need for services

A service that requires immediate medical attention (but isn't an emergency) is an urgently needed service if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. 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, aren't considered urgently needed even if you're outside our plan's service area or our 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 Get 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're still entitled to care from our plan.

Visit medicare.gov/providers-services/disaster-emergency for information on how to get needed care during a disaster.

If you can't use a network provider during a disaster, our plan will allow you to get care from out-of-network providers at in-network cost sharing.

SECTION 4 What if you're billed directly for the full cost of covered services?

If you paid more than our plan cost-sharing for covered services, or if you got a bill for the full cost of covered medical services, you can ask us to pay our share of the cost of covered services. Go to Chapter 5 for information about what to do.

Section 4.1 If services aren't covered by our plan, you must pay the full cost

Tufts Medicare Preferred HMO Prime No Rx (HMO) covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4. If you get services that aren't covered by our plan or you get services out-of-network without authorization that are not emergency or urgently needed services, you're responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you use 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 Medical services 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 ask for volunteers to participate in the study. When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that's not related to the study) through our plan.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for covered services you get as part of the study. If you tell us you're in a qualified clinical trial, then

you're 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'll reimburse the difference between what you paid and the in-network cost sharing. You'll need to provide documentation to show us how much you paid.

If you want to participate in any Medicare-approved clinical research study, you don't need to tell us or get approval from us or your PCP. The providers that deliver your care as part of the clinical research study don't need to be part of our plan's network. (This doesn't apply to covered benefits that require a clinical trial or registry to assess the benefit, including certain benefits requiring coverage with evidence development (NCDs-CED) and investigational exemption device (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.)

While you don't need our plan's permission to be in a clinical research study, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

If you participate in a study not approved by Medicare, you'll be responsible for paying all costs for your participation in the study.

Section 5.2 Who pays for services in a clinical research study

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you get 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's part of the research study.
- Treatment of side effects and complications of the new care.

After Medicare pays 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'll pay the same amount for services you get as part of the study as you would if you got these services from our plan. However, you must submit documentation showing how much cost-sharing you paid. Go to Chapter 5 for more information on submitting requests for payments.

> *Example of cost sharing in a clinical trial:* Let's say you have a lab test that costs $100 as part of the research study. Your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan. In this case, Original Medicare would pay $80 for the test, and you would pay the $20 copay required under Original Medicare. You would notify our plan that you got a qualified clinical trial service and submit documentation, (like a provider bill) to our plan. Our plan would then directly pay you $10. This makes your net payment for the test $10, the same amount you pay under our plan's benefits.

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

- Generally, Medicare won't pay for the new item or service the study is testing unless Medicare would cover the item or service even if you weren't in a study.
- Items or services provided only to collect data and not used in your direct health care. For example, Medicare won't pay for monthly CT scans done as part of a study if your medical condition would normally require only one CT scan.
- Items and services provided by the research sponsors free-of-charge for people in the trial.

Get more information about joining a clinical research study

Get more information about joining a clinical research study in the Medicare publication *Medicare and Clinical Research Studies* available at Medicare.gov/coverage/clinical-research-studies. You can also call 1-800-MEDICARE (1-800-633-4227) TTY users call 1-877-486-2048.

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

Section 6.1 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'll instead cover 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 How to get 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're conscientiously opposed to getting medical treatment that is **non-excepted**.

- **Non-excepted** medical care or treatment is any medical care or treatment that's *voluntary* and *not required* by any federal, state, or local law.
- **Excepted** medical treatment is medical care or treatment you get that's *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 only covers non-religious aspects of care.

- If you get services from this institution provided to you in a facility, the following conditions apply:
    - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care;
    - – and – You must get approval in advance from our plan before you're admitted to the facility, or your stay won't 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 You won't own some durable medical equipment after making a certain number of payments under our plan

Durable medical equipment (DME) includes items like 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 members to use in the home. The member always owns some DME items, like prosthetics. Other types of DME 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 Prime No Rx (HMO), however, you usually won't get ownership of rented DME items no matter how many copayments you make for the item while a member of our plan**. You won't get ownership even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under some limited circumstances, we'll transfer ownership of the DME item to you. Call Member Services at 1-800-701-9000 (TTY users call 711) for more information.

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

If you didn't get ownership of the DME item while in our plan, you'll have to make 13 new consecutive payments after you switch to Original Medicare to own the DME item. The payments you made while enrolled in our plan don't count towards these 13 payments.

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 don't count. You'll 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 didn't get ownership of the item while in our plan. You then go back to Original Medicare. You'll have to make 13 consecutive new payments to own the item once you rejoin Original Medicare. Any payments you already made (whether to our plan or to Original Medicare) don't count.

Section 7.2 Rules for oxygen equipment, supplies and maintenance

If you qualify for Medicare oxygen equipment coverage, Tufts Medicare Preferred HMO Prime No Rx (HMO) 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 Prime No Rx (HMO) or no longer medically require oxygen equipment, the oxygen equipment must be returned.

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

Original Medicare requires an oxygen supplier to provide you services for 5 years. During the first 36 months, you rent the equipment. For the remaining 24 months, the supplier provides the equipment and maintenance (you're still responsible for applicable cost sharing for oxygen). After 5 years, you can choose to stay with the same company or go to another company. At this point, the 5-year cycle starts over again, even if you stay with the same company, and you're again required to pay copayments for the first 36 months. If you join or leave our plan, the 5-year cycle starts over.

CHAPTER 4:

Medical Benefits Chart (what's covered and what you pay)

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

The Medical Benefits Chart lists your covered services and shows how much you pay for each covered service as a member of Tufts Medicare Preferred HMO Prime No Rx (HMO). This section also gives information about medical services that aren't covered and explains limits on certain services.

Section 1.1 Out-of-pocket costs you may pay for covered services

Types of out-of-pocket costs you may pay for covered services include:

- **Copayment:** the fixed amount you pay each time you get certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart tells you more about your copayments.)
- **Coinsurance:** the 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 tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program don't pay deductibles, copayments or coinsurance. If you're in one of these programs, be sure to show your proof of Medicaid or QMB eligibility to your provider.

Section 1.2 What's the most you'll pay for covered medical services?

Medicare Advantage Plans have limits on the total amount you have to pay out of pocket each year for in-network medical services covered by our plan. This limit is called the maximum out of pocket (MOOP) amount for medical services. **For calendar year 2027 the MOOP amount is $3,850.**

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 plan premium doesn't count toward your maximum out-of-pocket amount.) In addition, amounts you pay for some services don't 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 $3,850, you won't 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 also limits your out-of-pocket costs for certain types of services

In addition to the maximum out-of-pocket amount for covered services (described above), we also have a separate maximum out-of-pocket amount that applies only to certain types of services.

- Our plan has a maximum out-of-pocket amount of $900 for inpatient acute care. Once you've paid $900 out of pocket for inpatient acute care, our plan will cover these services at no cost to you for the rest of the calendar year. Both the maximum out-of-pocket amount for all covered medical services and the maximum out-of-pocket amount for inpatient acute care apply to your covered inpatient acute care. This means that once you've paid *either* $3,850 for all covered medical services *or* $900 for your inpatient acute care, our plan will cover your inpatient acute care at no cost to you for the rest of the year. The Medical Benefits Chart shows the service category out-of-pocket maximums.
- Our plan has a maximum out-of-pocket amount of $900 for inpatient rehabilitation services. Once you've paid $900 out of pocket for inpatient rehabilitation services, our plan will cover these services at no cost to you for the rest of the calendar year. Both the maximum out-of-pocket amount for all covered medical services and the maximum out-of-pocket amount for inpatient rehabilitation services apply to your covered inpatient rehabilitation services. This means that once you've paid *either* $3,850 for all covered medical services *or* $900 for your inpatient rehabilitation services, our plan will cover your inpatient rehabilitation services at no cost to you for the rest of the year. The Medical Benefits Chart shows the service category out-of-pocket maximums.
- Our plan has a maximum out-of-pocket amount of $900 for inpatient services in a psychiatric hospital. Once you've paid $900 out of pocket for inpatient services in a psychiatric hospital, our plan will cover these services at no cost to you for the rest of the calendar year. Both the maximum out-of-pocket amount for all covered medical services and the maximum out-of-pocket amount for inpatient services in a psychiatric hospital apply to your covered inpatient services in a psychiatric hospital. This means that once you've paid *either* $3,850 for all covered medical services *or* $900 for your inpatient services in a psychiatric hospital, our plan will cover your inpatient services in a psychiatric hospital at no cost to you for the rest of the year. The Medical Benefits Chart shows the service category out-of-pocket maximums.

Section 1.4 Providers aren't allowed to balance bill you

As a member of Tufts Medicare Preferred HMO Prime No Rx (HMO), you have an important protection because you only have to pay your cost-sharing amount when you get services covered by our plan.

Providers can't bill you for 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's a dispute and we don't pay certain provider charges.

Here's how protection from balance billing works:

- If your cost sharing is a copayment (a set amount of dollars, for example, $15.00), 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), you never pay more than that percentage. However, your cost depends on which type of provider you see:
  - If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (this is set in the contract between the provider and our plan).
  - If you get 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. (Our 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 get the covered services from an out-of-network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Our plan covers services from out-of-network providers only in certain situations, such as when you get a referral, or for emergencies or for urgently needed services outside the service area.)
- If you think a provider has balance billed you, call Member Services at 1-800-701-9000 (TTY users call 711).

SECTION 2 The Medical Benefits Chart shows your medical benefits and costs

The Medical Benefits Chart on the next pages lists the services Tufts Medicare Preferred HMO Prime No Rx (HMO) covers and what you pay out of pocket for each service. The services listed in the Medical Benefits Chart are covered only when these are met:

- Your Medicare-covered services must be provided according to the Medicare coverage guidelines.
- Your services (including medical care, services, supplies, equipment, and Part B 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 can't 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 get your care from a network provider. In most cases, care you get from an out-of-network provider won't be covered, unless it's emergency or urgent care, or unless our plan or a network provider gave you a referral. This means you pay the provider in full for out-of-network services you get.
- You have a primary care provider (a PCP) providing and overseeing your care. In most situations, your PCP must give you approval in advance (a referral) before you can see other providers in our plan's network.
- Some services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval from us in advance (sometimes called prior authorization). 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*. (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You 2027* handbook. View it online at Medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227) TTY users call 1-877-486-2048.)
- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you. However, if you're also treated or monitored for an existing medical condition during the visit when you get the preventive service, a copayment will apply for the care you got for the existing medical condition.
- If Medicare adds coverage for any services during 2027, either Medicare or our plan will cover those services.

 This apple shows preventive services in the Medical Benefits Chart.

Medical Benefits Chart

Covered Service	What you pay
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS).	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 under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • 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 • Not associated with pregnancy An additional 8 sessions will be covered for 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. **Provider Requirements:** Physicians may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the	$20 copayment for each Medicare-covered service. A referral may be required from your PCP before you receive services. Your PCP will provide this referral if needed. Refer to Chapter 3 Section 2.3 for more details on referral process.

Covered Service	What you pay
Acupuncture for chronic low back pain - continued 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. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations. 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. Additional acupuncture services are eligible for reimbursement under your **Wellness Allowance**. See **Wellness Allowance** benefit description for full details.	
Ambulance services 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 if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't 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. Ambulance services are covered worldwide.	$175 copayment per one way trip for Medicare-covered Ground Ambulance service. ***Prior authorization may be required for non-emergency transportation.*** $175 copayment per one way trip for Medicare-covered Air Ambulance service. ***Prior authorization may be required for non-emergency transportation.***

Covered Service	What you pay
Ambulance services - continued	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. If your condition does not meet Medicare criteria and you utilize the ambulance service, you will then be responsible for the entire cost. If you have questions about coverage for ambulance services, please contact Member Services. Wheelchair van (chair car) transportation is not covered by Medicare even if provided by an ambulance company.
Non-ambulance transportation 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.	$0 copayment for covered transportation when ordered by the discharging hospital.
Annual routine physical exam 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	$0 copayment. If you receive services that address a medical condition during the same office visit,

Covered Service	What you pay
Annual routine physical exam - continued complete prescription medication review; and a review of any recent hospitalizations. Covered once every calendar year.	additional cost-share may apply.
Annual wellness visit 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. **Note**: Your first annual wellness visit can't take place within 12 months of your *Welcome to Medicare* preventive visit. However, you don't need to have had a *Welcome to Medicare* visit to be covered for annual wellness visits after you've had Part B for 12 months.	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.
Bone mass measurement For qualified people (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: • 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.

Covered Service	What you pay
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 referral.	$0 copayment for each Medicare-covered service. A referral may be required from your PCP before you receive services. Your PCP will provide this referral if needed. Refer to Chapter 3 Section 2.3 for more details on referral process. ***Prior authorization may be required.***
Our plan covers these comprehensive programs if you've had at least one of these conditions: • Heart attack in the last 12 months • Coronary artery bypass surgery • Stable angina pectoris (chest pain) • Heart valve repair or replacement • Coronary angioplasty (a medical procedure used to open a blocked artery) or coronary stenting (a procedure used to keep an artery open) • Heart or heart and lung transplant • Stable chronic heart failure Coverage limitations: You can get up to 36 cardiac rehabilitation sessions. You can have 2 sessions per day (each lasting 1 hour), and the program can last up to 36 weeks. If you qualify, you may be able to get 36 more sessions that can be spread out over a longer time period.	$0 copayment for each Medicare-covered service. A referral may be required from your PCP before you receive services. Your PCP will provide this referral if needed. Refer to Chapter 3 Section 2.3 for more details on referral process. ***Prior authorization may be required.***
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	There is no coinsurance, copayment, or deductible for

Covered Service	What you pay
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) - continued doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	the intensive behavioral therapy cardiovascular disease preventive benefit.
Cardiovascular disease screening tests 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: • Pap tests and pelvic exams once every 24 months for all women • One pap test every 12 months if at high risk of cervical or vaginal cancer or if of childbearing age and have had an abnormal pap test within the past 3 years	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services Covered services include: • Manual manipulation of the spine to correct a vertebral subluxation	$15 copayment for each Medicare-covered service. A referral may be required from your PCP before you receive services. Your PCP will provide this referral if needed. Refer to Chapter 3 Section 2.3 for more details on referral process.

Covered Service	What you pay
Chiropractic services - continued	***Prior authorization may be required.***
Additional coverage provided by Tufts Medicare Preferred HMO Prime No Rx (HMO) • Chiropractic initial evaluation covered once per calendar year	$15 copayment per visit A referral may be required from your PCP before you receive services. Your PCP will provide this referral if needed. Refer to Chapter 3 Section 2.3 for more details on referral process. ***Prior authorization may be required.*** Other forms of chiropractic care are not covered benefits. See Chapter 4, Section 3 for services excluded from coverage.
Colorectal cancer screening The following screening tests are covered: • 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 aren't at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 45 years and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, coverage of a screening computed tomography	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. 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 a $0 copayment.

Covered Service	What you pay
Colorectal cancer screening - continued colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient got a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or computed tomography colonography. • 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. • 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. • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.	
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for	$15 copayment for each Medicare-covered service. A referral may be required from your PCP before you receive services. Your PCP will provide this referral if needed. Refer to Chapter 3 Section 2.3 for more

Covered Service	What you pay
Dental services - continued	
radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. Refer to Section 2.1 of this chapter for a description of the supplemental dental benefit you get if you enroll in the **Tufts Medicare Preferred Dental Option**.	details on referral process. ***Prior authorization may be required.*** 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.
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 these 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 2 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.

Covered Service	What you pay
Diabetes self-management training, diabetic services, and supplies	
For all people who have diabetes (insulin and non-insulin users). Covered services include: • 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.	$0 copayment for each Medicare-covered service. ***Prior authorization may be required.*** 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. Coverage for blood glucose monitors and blood glucose test strips is limited to the Accu-Chek products manufactured by Roche Diabetes Care, Inc. Please note, there is no preferred brand for lancets or glucose control solutions. Coverage for therapeutic Continuous Glucose Monitors (CGMs) is limited to Dexcom and FreeStyle Libre products that are considered Durable Medical Equipment (DME) by Medicare. Diabetic testing supplies, including test strips, lancets, glucose meters, and CGMs are

Covered Service	What you pay
Diabetes self-management training, diabetic services, and supplies - continued	
	also covered at participating retail or mail-order pharmacies. You must first obtain a prescription from your PCP or physician treating your diabetes for covered diabetic supplies (including therapeutic custom-molded shoes).
• 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 2 additional pairs of inserts, or one pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes) including fitting.	$0 copayment for each Medicare-covered service. ***Prior authorization may be required.***
• Diabetes self-management training under certain conditions.	$0 copayment for each Medicare-covered service.
• 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. **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.	

Covered Service	What you pay
Durable medical equipment (DME) and related supplies (For a definition of durable medical equipment, go to Chapter 10 and Chapter 3) Covered items include, but aren't 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.	10% coinsurance for each Medicare-covered service Your cost sharing for Medicare oxygen equipment coverage is 10% every month. After 36 months, you will stop paying your 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 benefit design at that time. Above cost shares also apply if prior to enrolling in Tufts Medicare Preferred HMO Prime No Rx (HMO) you had made 36 months of rental payments for oxygen equipment coverage. ***Prior authorization may be required.***

Covered Service	What you pay
Durable medical equipment (DME) and related supplies - continued	
	Refer to the **Diabetes self-management training, diabetic services and supplies** section in this Medical Benefits Chart for coverage details of diabetic supplies.
Additional items covered by Tufts Medicare Preferred: Bathroom Safety Equipment The following Bathroom Safety Equipment is covered for members who have a functional impairment when having the item will improve safety (installation not covered): • 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	You pay 10% coinsurance for bathroom safety equipment upon written prescription from a network provider to a network DME or Orthotics and Prosthetics (O&P) supplier.
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. Note: • 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 **prior authorization** on file. • For help determining whether items/supplies are covered and/or whether prior authorization is required, and/or	

Covered Service	What you pay
Durable medical equipment (DME) and related supplies - continued whether a DME supplier is in our network, call Member Services.	
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services • Needed to evaluate or stabilize an emergency medical condition 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're 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's quickly getting worse. Cost sharing for necessary emergency services you get out-of-network is the same as when you get these services in-network. Your plan includes worldwide coverage for emergency care.	$130 copayment for each Medicare-covered service. If your visit to the emergency room also 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 emergency care copayment applies. 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**

Covered Service	What you pay
Emergency care - continued	
	surgical centers in this chart for more details. If you are held for observation following the emergency room visit, you will only pay the emergency care copay or observation copay, whichever is higher. See **Outpatient hospital observation** in this chart for more details including applicable copay. You do not pay the emergency care copay 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). In some cases, you may have to pay an additional cost-share for the services provided by certain providers in the emergency room. If you get 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 our plan and your cost is the cost sharing you would pay at a network hospital.

Covered Service	What you pay
Health and wellness education programs **Wellness Allowance** 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: 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 (healthyliving4me.org), the Arthritis Foundation® (arthritis.org/health-wellness), and Triple-A (aaa.com). Other, specific examples include: ○ Chronic disease self-management programs ○ Driver improvement and/or safety programs ○ Healthy IDEAS (healthyideasprograms.org) ○ Powerful Tools for Caregivers (powerfultoolsforcaregivers.org) ○ EnhanceWellness (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: ○ One fitness tracker or heart rate monitor per year (Includes smart watches, like the Apple Watch.) ○ Memory fitness programs that exercise the brain to improve aspects of cognition like memory, attention,	The plan reimburses you up to $150 per calendar year toward eligible activities, items, and/or programs. You pay all charges over $150 per calendar year. Sales tax is not eligible for reimbursement. Reimbursement requests must be received by Tufts Medicare Preferred by no later than March 31st of the following year.

Covered Service	What you pay
Health and wellness education programs - continued 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.) • 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. • 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	

Covered Service	What you pay
Health and wellness education programs - continued 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. 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. 5. The following Alternative Therapies: • 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. • 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	

Covered Service	What you pay
Health and wellness education programs - continued 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. 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. 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. 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 thpmp.org/forms. Send the completed form with any required documents to the address shown on the form. If you have any questions, contact Member Services.	

Covered Service	What you pay
Health and wellness education programs - continued **SilverSneakers® Fitness** (available to Tufts Medicare Preferred HMO Prime No Rx (HMO) members who live in Worcester County only) 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 classes[2] and use exercise equipment and other amenities, at no additional cost to you. Enroll in as many locations as you like, at any time. 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. 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: • Walking, which includes a pedometer; • Strength, which includes resistance tubing; • Toning, which includes an exercise ball; or • Yoga, which includes a yoga strap. Each at-home exercise kit also comes with a Quick Start Guide.	You pay $0 for this program (applies to Tufts Medicare Preferred HMO Prime No Rx (HMO) members who live in Worcester County only).

Covered Service	What you pay
Health and wellness education programs - continued Visit thpmp.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. **Always talk with your doctor before starting an exercise program.** Footnotes: [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. Burnalong is a registered trademark of Burnalong, Inc. SilverSneakers is a registered trademark of Tivity Health, Inc. © 2024 Tivity Health, Inc. All rights reserved.	
Weight Management Programs 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. 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 thpmp.org/forms. Send the completed form with any required documents to the address shown on the form. If you have any questions, contact Member Services.	The plan will reimburse members up to $150 per calendar year towards program fees for weight-loss programs. Sales tax is not eligible for reimbursement. Reimbursement requests must be received by Tufts Medicare Preferred by no later than March 31st of the following year. The Weight Management Programs Allowance and the

Covered Service	What you pay
Health and wellness education programs - continued	Wellness Allowance are separate allowances.
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.	$15 copayment for a Medicare-covered diagnostic hearing exam.
Additional routine 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.	$0 copayment for an annual routine hearing test.
Fitting-evaluation(s) for hearing aids *Cost-shares for these items/services do not count toward your annual maximum out-of-pocket amount.	You pay $0 for hearing aid fitting evaluations received through **TruHearing, Inc.** If diagnostic tests are performed, additional cost shares may apply.

Covered Service	What you pay
Hearing services - continued	
Hearing aids • **All types** Note: • **TruHearing, Inc.** is an in-network hearing aid provider that can be contacted at 1-866-335-9426. • The hearing aid formulary mentioned in the right hand column is available through **TruHearing, Inc.** at the number listed above. Hearing aids not listed on the **TruHearing, Inc.** formulary are not covered. *Cost-shares for these items/services do not count toward your annual maximum out-of-pocket amount.	You are eligible for up to 2 covered hearing aids per year (1 hearing aid per ear) through **TruHearing, Inc**. To be covered, the hearing aids must be on the **TruHearing, Inc**. formulary and must be purchased through **TruHearing, Inc**. You pay a copayment for each covered hearing aid, and the copayment amount depends on the type of hearing aid purchased through the **TruHearing, Inc.** formulary. $250 copay for Standard level hearing aid. $475 copay for Superior level hearing aid. $650 copay for Advanced level hearing aid. $850 copay for Advanced Plus level hearing aid.

Covered Service	What you pay
Hearing services - continued	$1,150 copay for Premier level hearing aid.
HIV screening For people who ask for an HIV screening test or are at increased risk for HIV infection, we cover: • One screening exam every 12 months If you are pregnant, we cover: • Up to 3 screening exams during a pregnancy	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
Home health agency care Before you get 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. Covered services include, but aren't limited to: • 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	$0 copayment for each Medicare-covered service. A referral may be required from your PCP before you receive these services. Your PCP will provide this referral if needed. Refer to Chapter 3 Section 2.3. ***Prior authorization may be required.***

Covered Service	What you pay
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person 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). Covered services include, but aren't limited to: • Professional services, including nursing services, furnished in accordance with our 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	You pay $0 for Medicare-covered home infusion therapy services. ***Prior authorization may be required.***
Hospice care You're 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 can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you're admitted to a hospice, you have the right to stay in our plan; if you stay in our plan you must continue to pay plan premiums.	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 Prime No Rx (HMO).

Covered Service	What you pay
Hospice care - continued **For hospice services and services covered by Medicare Part A or B that are related to your terminal prognosis:** 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're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. You'll be billed Original Medicare cost sharing. **For services covered by Medicare Part A or B not related to your terminal prognosis:** If you need non-emergency, non-urgently needed services covered under Medicare Part A or B that aren't 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 (like if there's a requirement to get prior authorization). • If you get the covered services from a network provider and follow plan rules for getting service, you pay only our plan cost-sharing amount for in-network services • If you get the covered services from an out-of-network provider, you pay the cost sharing under Original Medicare **For services covered by Tufts Medicare Preferred HMO Prime No Rx (HMO) but not covered by Medicare Part A or B**: Tufts Medicare Preferred HMO Prime No Rx (HMO) will continue to cover plan-covered services that aren't covered under Part A or B whether or not they're related to your terminal prognosis. You pay our plan cost-sharing amount for these services. **Note:** If you need non-hospice care (care that's not related to your terminal prognosis), contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	

Covered Service	What you pay
Immunizations Covered Medicare Part B services include: • 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've never received a complete series, you don't know your vaccination history, or you have any other condition that puts you at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you're at risk and they meet Medicare Part B coverage rules	There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines, and other vaccines if you are at risk and they meet Medicare Part B coverage rules. Medicare Part B cost share applies for other vaccines that meet Medicare Part B coverage rules and received when you're not at risk. See the Medicare Part B prescription drugs section in this Medical Benefits Chart for applicable cost shares.
In-home safety assessment **Additional service covered by Tufts Medicare Preferred** The in-home safety assessment is performed when recommended by the member's PCP, Case Manager, or other health care provider. This assessment is for members who do not qualify for Original Medicare's in-home safety assessment. The in-home safety assessment includes evaluating a member's risk for a fall by evaluating: 1. The Get up and Go test 2. Review of medications 3. A detailed history of falls, balance problems, or incontinence	$0 copayment.

Covered Service	What you pay
In-home safety assessment - continued 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)	
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you'e discharged is your last inpatient day. For care in a general acute care hospital, you are covered for as many days as medically necessary: there is no limit. Medicare benefit periods do not apply to acute hospital stays. For care in a rehabilitation or long-term acute care hospital, 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. Covered services include but aren't limited to: • 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	Each time you are admitted to an acute care hospital, acute rehabilitation hospital, or long-term acute care hospital, you pay $300. You will not pay more than $900 for inpatient hospital covered services in a calendar year. 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 hospital that provides similar type of care for the purpose of continuing your care, even if you do not return to the original admitting hospital for additional care prior to discharge. A transfer from a facility to another facility that provides a different type of care (such as from a skilled nursing facility to an acute hospital) counts as a separate admission and will require a separate applicable copay.

Covered Service	What you pay
Inpatient hospital care - continued • 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 abuse services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're 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 Prime No Rx (HMO) provides transplant services at a location outside the pattern of care for transplants in your community and you choose to get transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion. Usually transplants are only covered in our service area.	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. 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.
• Blood - including storage and administration. Coverage of whole blood and packed red cells starts with the first pint of blood that you need. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an	***Prior authorization may be required.***

Covered Service	What you pay
Inpatient hospital care - continued outpatient. If you're not sure if you're an inpatient or an *outpatient*, ask the hospital staff. Get more information from the Medicare fact sheet *Medicare Hospital Benefits* available at 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.	
Inpatient services in a psychiatric hospital Covered services include mental health care services that require a hospital stay. There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital. 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. This may require a transfer from the hospital your PCP uses for medical and surgical services to the facility designated for mental health services.	Each time you are admitted to a psychiatric hospital for covered services, you pay $300. You will not pay more than $900 for inpatient services in a psychiatric hospital in a calendar year. Medicare hospital benefit periods are used to determine the total number of days covered for inpatient mental health care that count toward the 190-day lifetime limit. (See definition of benefit periods in the chapter titled Definitions of important words.) However, the cost-sharing described above applies each time you are admitted to the hospital, even if you are admitted multiple times within a benefit period. Cost shares are applied starting on the first day of admission and do not include the day of discharge.

Covered Service	What you pay
Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay If you've used up your inpatient benefits or if the inpatient stay isn't reasonable and necessary, we won't cover your inpatient stay. In some cases, we'll cover certain services you get while you're in the hospital or the skilled nursing facility (SNF). Covered services include, but aren't limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy	$0 copayment for Medicare-covered services provided in the hospital or skilled nursing facility (SNF).

Covered Service	What you pay
Medical nutrition therapy	
This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during the first year you get 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 get 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.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.
Additional medical nutrition therapy 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.	$0 copayment for each additional, hourly session of one-on-one medical nutrition therapy services.
Medicare Diabetes Prevention Program (MDPP)	
MDPP services are covered for eligible people under all Medicare health plans. 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 sustain weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.

Covered Service	What you pay
Medicare Part B drugs **These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include:** • Drugs that usually aren't self-administered by the patient and are injected or infused while you get 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 our plan • The Alzheimer's drug, Leqembi® (generic name lecanemab) 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 • Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug • 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 • 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	**Medicare Part B Insulin Drugs** $0 copayment for each Medicare-covered service. ***Prior authorization may be required.*** **Other Medicare Part B Drugs** $0 copayment for each Medicare-covered service. ***Prior authorization may be required.*** **Medicare Part B Chemotherapy/Radiation Drugs** $0 copayment for each Medicare-covered service.

Covered Service	What you pay
Medicare Part B drugs - continued	
form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug • 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 covered under Medicare Part B • Calcimimetic and phosphate binder 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 • Parenteral and enteral nutrition (intravenous and tube feeding) Part B Step Therapy Drug Categories: • Rare Diseases • Autoimmune • Iron preparations, Parenteral • Oncology • Oncology, Supportive • Retinal Disorders • Triamcinolone Acetonide Injection	***Prior authorization may be required.*** These prescription drugs are covered under Part B and not covered under the Medicare Prescription Drug Program (Part D). Part B drugs may be subject to Step Therapy requirements.

Covered Service	What you pay
Medicare Part B drugs - continued • Viscosupplements • Botulinum Toxins • Endocrine Disorders This link will take you to a list of Part B drugs that may be subject to Step Therapy: point32health.org/provider/medical-benefit-drug-medical-necessity-guidelines/ We also cover some vaccines under our Part B drug benefit.	
Obesity screening and therapy to promote sustained weight loss 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.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • 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 counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	$15 copayment per encounter for each Medicare-covered service.

Covered Service	What you pay
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but aren't limited to:	
• X-rays	$0 copayment per day for Medicare-covered X-rays. ***Prior authorization may be required.***
• Radiation (radium and isotope) therapy including technician materials and supplies	$0 copayment per day for each Medicare-covered service. ***Prior authorization may be required.***
• Surgical supplies, such as dressings • Splints, casts, and other devices used to reduce fractures and dislocations	10% coinsurance for Medicare-covered medical supplies; you pay 0% coinsurance for Medicare-covered medical supplies provided as part of an office visit.
• Laboratory tests	$0 copayment for each Medicare-covered service. ***Prior authorization may be required.***

Covered Service	What you pay
Outpatient diagnostic tests and therapeutic services and supplies - continued	
• Blood - including storage and administration. Coverage of whole blood and packed red cells starts with the first pint of blood that you need.	$0 copayment for each Medicare-covered service.
• Other outpatient diagnostic tests. Includes but not limited to, sleep studies, EKG, stress tests, vascular studies, and breathing capacity tests.	$0 copayment for each Medicare-covered service. ***Prior authorization may be required.***
• Diagnostic radiology services, such as ultrasound, nuclear cardiac imaging, PET, MRI, and CT scan.	20% coinsurance up to $75 per day for Medicare-covered diagnostic radiology services. Your copayment limit of $75 per day applies even if multiple diagnostic radiology services are performed. ***Prior authorization may be required.*** If you have multiple services performed by different providers, separate cost-sharing will apply as applicable. 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.

Covered Service	What you pay
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're 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 aren't sure if you're an outpatient, ask the hospital staff. Get more information from the Medicare fact sheet *Medicare Hospital Benefits* available at 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.	$200 copayment per stay for each Medicare-covered service. If you have additional outpatient services while held in observation, additional cost share may apply. ***Prior authorization may be required.*** You do not pay the outpatient hospital observation copay 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.
Outpatient hospital services We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but aren't limited to: • Services in an emergency department	For cost shares that apply to Emergency services, see **Emergency care** in this chart.
• Services performed at an outpatient clinic	Please refer to **Physician/Practitioner**

Covered Service	What you pay
Outpatient hospital services - continued	
	Services, Including Doctor's Office Visits.
• Outpatient surgery or observation	For cost shares that apply to Observation services, see **Outpatient hospital observation** in this chart. For cost shares that apply to Outpatient surgery, see **Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers** in this chart.
• Laboratory and diagnostic tests billed by the hospital	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.
• Mental health care, including care in a partial hospitalization program, if a doctor certifies that inpatient treatment would be required without it	For cost shares that apply to Mental health care and partial hospitalization, see **Outpatient mental health care** and **Partial hospitalization services** in this chart. For cost shares that apply to Chemical dependency care, see

Covered Service	What you pay
Outpatient hospital services - continued	
	Outpatient substance use disorder services in this chart.
• X-rays and other radiology services billed by the hospital	Please refer to **Outpatient diagnostic tests and therapeutic services and supplies** in this chart.
• Medical supplies such as splints and casts	For cost shares that apply to medical supplies, see **Outpatient diagnostic tests and therapeutic services and supplies** in this chart.
• Certain drugs and biologicals you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're 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 aren't sure if you're an outpatient, ask the hospital staff. Get more information from the Medicare fact sheet *Medicare Hospital Benefits* available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227).	For cost shares that apply to drugs and biologicals that you can't give yourself, see **Medicare Part B prescription drugs** in this chart.
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker (CSW), clinical nurse specialist (CNS), licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner	

Covered Service	What you pay
Outpatient mental health care - continued	
(NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.	
• Services provided by a psychiatrist	$10 copayment for each Medicare-covered Individual Session. You pay $0 for brief office visits (up to 15 minutes) for the sole purpose of monitoring or changing drugs. $10 copayment for each Medicare-covered Group Session. You pay $0 for brief office visits (up to 15 minutes) for the sole purpose of monitoring or changing drugs.
• Services provided by other mental health care providers	$10 copayment for each Medicare-covered Individual Session. You pay $0 for brief office visits (up to 15 minutes) for the sole purpose of monitoring or changing drugs. $10 copayment for each Medicare-covered Group Session. You pay $0 for brief office visits (up to 15 minutes) for the sole purpose of monitoring or changing drugs.

Covered Service	What you pay
Outpatient mental health care - continued	
Outpatient rehabilitation services Covered services include physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	
• Services provided by a physical therapist or speech language therapist	$15 copayment for each Medicare-covered service. $0 for a post-outpatient surgical procedure physical therapy consultation prior to discharge. A referral may be required from your PCP before you receive these services. Your PCP will provide this referral if needed. Refer to Chapter 3 Section 2.3 for more details on referral process. ***Prior authorization may be required.***
• Services provided by an occupational therapist	$15 copayment for each Medicare-covered service. $0 for a post-outpatient surgical procedure

Covered Service	What you pay
Outpatient rehabilitation services - continued	
	occupational therapy consultation prior to discharge. A referral may be required from your PCP before you receive these services. Your PCP will provide this referral if needed. Refer to Chapter 3 Section 2.3 for more details on referral process. ***Prior authorization may be required.*** Please refer to **Cardiac rehabilitation services** and **Pulmonary rehabilitation services** in this chart for coverage information for these services.
Outpatient substance use disorder services 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. The coverage available for these services is subject to the same rules generally applicable to the coverage of outpatient hospital services.	$10 copayment for each Medicare-covered Individual Session. $10 copayment for each Medicare-covered Group Session. Please refer to **Partial hospitalization services and intensive outpatient services**

Covered Service	What you pay
Outpatient substance use disorder services - continued	
	in this chart for coverage information for this service if a provider certifies that inpatient treatment would be necessary without it.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient.	
• Services provided at an outpatient hospital	$0 copayment for Medicare-covered colonoscopies. $200 copayment 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 facility. A referral may be required from your PCP before you receive these services. Your PCP will provide this referral if needed. Refer to Chapter 3 Section 2.3 for more details on referral process. ***Prior authorization may be required.***

Covered Service	What you pay
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers - continued	
• Services provided at an ambulatory surgical center	$0 copayment for Medicare-covered colonoscopies. $100 copayment 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. A referral may be required from your PCP before you receive these services. Your PCP will provide this referral if needed. Refer to Chapter 3 Section 2.3 for more details on referral process. ***Prior authorization may be required.***
Partial hospitalization services and intensive outpatient services *Partial hospitalization* is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center that's more intense than care you get 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.	$55 copayment per visit for each Medicare-covered service.

Covered Service	What you pay
Partial hospitalization services and intensive outpatient services - continued *Intensive outpatient service* 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's more intense than care you get 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.	$55 copayment per visit for each Medicare-covered service.
Physician/practitioner services, including doctor's office visits Covered services include:	
• Medically necessary medical care or surgery services you get in a physician's office by a primary care provider	$10 copayment for each Medicare-covered service. You pay $0 copayment for a covered communication with your primary care provider through an online patient portal (also called e-visit).
• Medically necessary medical care or surgery services you get in a certified ambulatory surgical center, hospital outpatient department, or any other location	See **Outpatient Surgery** earlier in this chart for any applicable cost share amounts for ambulatory surgical center visits or in a hospital outpatient setting.
• Consultation, diagnosis, and treatment by a specialist	$20 copayment for each Medicare-covered service. You pay $0 copayment for a covered communication with a

Covered Service	What you pay
Physician/practitioner services, including doctor's office visits - continued	
	specialist through an online patient portal (also called e-visit). A referral may be required from your PCP before you receive services. Your PCP will provide this referral if needed. Refer to Chapter 3 Section 2.3 for more details on referral process.
• Other health care professionals	PCP or specialist copayment applies depending on the Medicare-covered service. You pay $0 copayment for a covered communication with a health care professional other than your primary care provider or a specialist through an online patient portal (also called e-visit). A referral may be required from your PCP before you receive services. Your PCP will provide this referral if needed. Refer to Chapter 3 Section 2.3 for more details on referral process.
• Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment	Applicable PCP, specialist, or hearing exam copayment applies depending on the Medicare-covered service. Refer to **Hearing services** in

Covered Service	What you pay
Physician/practitioner services, including doctor's office visits - continued	
	this chart for hearing exam cost shares.
• 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	You will pay the cost-sharing that applies to specialist services (as described under **Physician/Practitioner Services, Including Doctor's Office Visits** above). A referral may be required from your PCP before you receive services. Your PCP will provide this referral if needed. Refer to Chapter 3 Section 2.3 for more details on referral process.
• Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location	You will pay the cost-sharing that applies to specialist services (as described under **Physician/Practitioner Services, Including Doctor's Office Visits** above). A referral may be required from your PCP before you receive services. Your PCP will provide this referral if needed. Refer to Chapter 3 Section 2.3 for more details on referral process.
• Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location	You will pay the cost-sharing that applies to PCP or specialist services depending on the type of Medicare-covered service provided (as described under **Physician/Practitioner**

Covered Service	What you pay
Physician/practitioner services, including doctor's office visits - continued	
	Services, Including Doctor's Office Visits above). A referral may be required from your PCP before you receive services. Your PCP will provide this referral if needed. Refer to Chapter 3 Section 2.3 for more details on referral process.
• Telehealth services for diagnosis, evaluation, and treatment of mental health disorders	You will pay the cost-sharing that applies to PCP or specialist services depending on the type of Medicare-covered service provided (as described under **Physician/Practitioner Services, Including Doctor's Office Visits** above). A referral may be required from your PCP before you receive services. Your PCP will provide this referral if needed. Refer to Chapter 3 Section 2.3 for more details on referral process.
• Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers	You will pay the cost-sharing that applies to PCP or specialist services depending on the type of Medicare-covered service provided (as described under **Physician/Practitioner Services, Including Doctor's Office Visits** above). A referral may be required from your PCP before you receive services. Your PCP will provide this referral if needed. Refer to

Covered Service	What you pay
Physician/practitioner services, including doctor's office visits - continued	
	Chapter 3 Section 2.3 for more details on referral process.
• Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**: ○ 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	$0 copayment for virtual check-in with your PCP, other health care professionals, or a Specialist. A referral may be required from your PCP before you receive services. Your PCP will provide this referral if needed. Refer to Chapter 3 Section 2.3 for more details on referral process.
• Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if:** ○ 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	You will pay the cost-sharing that applies to PCP or specialist services depending on the type of Medicare-covered service provided (as described under **Physician/Practitioner Services, Including Doctor's Office Visits** above). A referral may be required from your PCP before you receive services. Your PCP will provide this referral if needed. Refer to Chapter 3 Section 2.3 for more details on referral process.
• Consultation your doctor has with other doctors by phone, internet, or electronic health record	$0 copayment for each Medicare-covered service.
• Second opinion by another network provider prior to surgery	You will pay the cost-sharing that applies to specialist services (as described under

Covered Service	What you pay
Physician/practitioner services, including doctor's office visits - continued	
	Physician/Practitioner Services, Including Doctor's Office Visits above). A referral may be required from your PCP before you receive services. Your PCP will provide this referral if needed. Refer to Chapter 3 Section 2.3 for more details on referral process.
• 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	Refer to **Annual routine physical exam** in this chart for cost shares that apply.
• Follow-up office visits following discharge from hospital, SNF, Community Behavioral Health Centers stay, outpatient observation, or partial hospitalization	$0 copayment for each Medicare-covered service.
• Additional telehealth services not covered by Medicare, including: ○ Primary Care Physician Services and Other Health Care Professionals (PAs & NPs) ○ Physician Specialist Services ○ Individual and Group Sessions for Behavioral Health Specialty Services ○ Individual and Group Sessions for Psychiatric Services ○ Opioid Treatment Program Services ○ Observation Services	You pay $0 copayment for remote patient monitoring services. A referral may be required from your PCP before you receive services. Your PCP will provide this referral if needed. Refer to Chapter 3 Section 2.3 for more details on referral process. ***Prior authorization may be required for remote patient monitoring services.***

Covered Service	What you pay
Physician/practitioner services, including doctor's office visits - continued ○ Individual and Group Sessions for Outpatient Substance Use Disorder Services ○ Kidney Disease Education Services ○ Diabetes Self-Management Training ○ Urgently Needed Services ○ Physical Therapy and Speech-Language Pathology Services ○ Remote Patient Monitoring Services ○ Pulmonary Rehabilitation Services ○ Partial Hospitalization Services ○ Intensive Outpatient Services ○ Cardiac Rehabilitation Services ○ Intensive Cardiac Rehabilitation 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 network providers from any location • 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	For all other additional telehealth services, you are responsible for the same cost-sharing that applies to each specific service, and the same requirements apply as for corresponding in-person visit. Please refer to relevant sections of this benefits chart for the applicable cost-share amounts and other requirements that may apply.
Podiatry services Covered services include: • 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)	You pay $15 for each Medicare-covered visit. A referral may be required from your PCP before you receive

Covered Service	What you pay
Podiatry services - continued	
	services. Your PCP will provide this referral if needed. Refer to Chapter 3 Section 2.3 for more details on referral process.
Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: • FDA-approved oral or injectable PrEP medication including the fee for injecting the drug, if applicable • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months • Up to 8 HIV screenings every 12 months • A one-time hepatitis B virus screening	There is no coinsurance, copayment, or deductible for the PrEP benefit.
Prostate cancer screening exams For men aged 50 and older, covered services include the following once every 12 months: • Digital rectal exam	$0 copayment for each Medicare-covered service.
• Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for an annual PSA test.

Covered Service	What you pay
Prosthetic and orthotic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include but aren't 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 – go to *Vision Care* later in this table for more detail. Note: • 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**; 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.	You pay 10% coinsurance upon written prescription from a network provider to a network DME or Orthotics and Prosthetics (O&P) supplier. ***Prior authorization may be required.***
Lymphedema Compression Treatment Items 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. 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	You pay 10% coinsurance upon written prescription from a network provider to a network DME or Orthotics and Prosthetics (O&P) supplier.

Covered Service	What you pay
Prosthetic and orthotic devices and related supplies - continued	
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: • 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	***Prior authorization may be required.***
Medical Supplies 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.	You pay 10% coinsurance for Medicare-covered medical supplies; you pay $0 for Medicare-covered medical supplies provided as part of an office visit.
Pulmonary rehabilitation services	
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.	$0 copayment for each Medicare-covered service. A referral may be required from your PCP before you receive these services. Your PCP will

Covered Service	What you pay
Pulmonary rehabilitation services - continued	provide this referral if needed. Refer to Chapter 3 Section 2.3 for more details on referral process. ***Prior authorization may be required.***
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults (including pregnant women) who misuse alcohol but aren't alcohol dependent. 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.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified people, an LDCT is covered every 12 months. **Eligible members are** people age 50 – 77 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 get 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. *For LDCT lung cancer screenings after the initial LDCT screening:* the members must get 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	There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision-making visit or for the LDCT.

Covered Service	What you pay
Screening for lung cancer with low dose computed tomography (LDCT) - continued screening counseling and shared decision-making visit for later lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	
Screening for Hepatitis C virus infection We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965. If you were born between 1945-1965 and aren't considered high risk, we cover a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for the Hepatitis C Virus.
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs 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. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We 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.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.

Covered Service	What you pay
Services to treat kidney disease Kidney disease and dialysis services include:	
• 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 6 sessions of kidney disease education services per lifetime	$0 copayment for each Medicare-covered service.
• 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)	20% coinsurance for Medicare-covered dialysis services.
• Inpatient dialysis treatments (if you're admitted as an inpatient to a hospital for special care)	Please refer to **Inpatient Hospital Care.**
• Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)	$0 copayment for each Medicare-covered service.
• Home dialysis equipment and supplies	Please refer to **Durable Medical Equipment and Related Supplies.**
• Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)	Please refer to **Home Health Agency Care.**
Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B Drugs, go to **Medicare Part B drugs** in this table.	

Covered Service	What you pay
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, go to Chapter 10. Skilled nursing facilities are sometimes called SNFs.) You are covered for up to 100 days each benefit period. A prior hospital stay is not required. Covered services include but aren't limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy and speech therapy • Drugs administered to you as part of our plan of care (this includes substances naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells starts with the first pint of blood that you need. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you get SNF care from network facilities. 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. • 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)	$0 copayment per day for days 1 to 20, $110 copayment per day for days 21 to 44, and $0 copayment per day for days 45 to 100 for Medicare-covered skilled nursing facility care. ***Prior authorization may be required.***

Covered Service	What you pay
Skilled nursing facility (SNF) care - continued • A SNF where your spouse or domestic partner is living at the time you leave the hospital	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.
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria: • Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • Are competent and alert during counseling • A qualified physician or other Medicare-recognized practitioner provides counseling We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year.) Smoking cessation telephonic counseling is also available through the Massachusetts Tobacco Cessation and Prevention Program (MTCP), MTCP is a free, evidence-based stop-smoking service developed by the Massachusetts Department of Public Health.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.

Covered Service	What you pay
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) - continued 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 mass.gov/massachusetts-tobacco-cessation-and-prevention-program-mtcp, or call 1-800-QUIT-NOW (1-800-784-8669).	
Supervised exercise therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • 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 (PA), or nurse practitioner (NP)/clinical nurse specialist (CNS) who must be trained in both basic and advanced life support techniques 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.	$0 copayment for each Medicare-covered service. A referral may be required from your PCP before you receive these services. Your PCP will provide this referral if needed. Refer to Chapter 3 Section 2.3 for more details on referral process. ***Prior authorization may be required.***

Covered Service	What you pay
Urgently needed services A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or, even if you're inside our plan's service area, it's unreasonable given your time, place, and circumstances to get this service from network providers. Our 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. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable. Your plan includes worldwide coverage for urgently needed services.	$30 copayment for each Medicare-covered service. This copayment is **not** waived if you are admitted as an inpatient to the hospital within one day for the same condition. 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.
Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts Note: ○ Services for the diagnosis and treatment of cataracts are considered diagnostic, and the copayment amount described in this section will apply. ○ Please see additional information below for coverage of routine eye exams.	$15 copayment for each Medicare-covered outpatient visit to a network provider or an optometrist in the EyeMed Vision Care network for services to diagnose and/or treat a disease or condition of the eye. A referral may be required from your PCP before you receive these services. Your PCP will provide this referral if needed. Refer to Chapter 3 Section 2.3

Covered Service	What you pay
Vision care - continued	
	for more details on referral process. No referral is required to see an optometrist, but you must use a provider in the EyeMed Vision Care network.
• For people who are at high risk for glaucoma, we 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	$0 copayment 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 the diagnostic eye exam copay described in the first bullet point above.
• For people with diabetes, screening for diabetic retinopathy is covered once per year	$0 copayment. A referral may be required from your PCP before you receive these services. Your PCP will provide this referral if needed. Refer to Chapter 3 Section 2.3 for more details on referral process. No referral is required to see an optometrist, but you must use a provider in the EyeMed Vision Care network.

Covered Service	What you pay
Vision care - continued	
• One pair of therapeutic (prescription) eyeglasses every calendar year (includes one pair of frames and single vision, bifocal, or trifocal lenses) after cataract surgery or as medically necessary or contact lenses for Keratoconus, Anisometropia, High Myopia, Aphakia, Congenital Aphakia, or Pseudophakia. Note: Coverage includes standard fitting and follow up after insertion of contact lenses as follows: ○ 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.	You pay $0 for one pair of eyeglasses with frames or contact lenses. No referral is required for this service, but you must obtain covered eyewear from a provider in the EyeMed Vision Care network.
• 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. (Tints, anti-reflective coating, U V lenses or oversize lenses are covered only when deemed medically necessary by the treating physician). Note: Coverage includes standard fitting and follow up after insertion of contact lenses as follows: ○ 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.	$0 copayment for one pair of Medicare-covered eyeglasses with frames or contact lenses after cataract surgery when obtained from a provider in the EyeMed Vision Care network. No referral is required for this service, but you must obtain covered eyewear from a provider in the EyeMed Vision Care network.

Covered Service	What you pay
Vision care - continued	
• One routine eye exam each calendar year	$15 copayment for one annual routine eye exam. 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. No referral is required for an annual routine eye exam, but you must use a provider in the EyeMed Vision Care network.
• 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 eyeglasses/contact lenses benefits described in the fourth and fifth bullet points listed above. To contact EyeMed Vision Care if you have any questions about this benefit, call 1-866-591-1863.	To access the annual eyewear benefit, you may purchase eyewear from any provider. Only one purchase is allowed per calendar year up to the benefit amount; any unused amount after the single purchase will expire and cannot be applied toward another purchase during the calendar year. If you choose an EyeMed Vision Care participating provider, you have the benefit of up to $150 per calendar year applied at the time of service, and would be responsible to pay for any remaining balance. The

Covered Service	What you pay
Vision care - continued	EyeMed Vision Care provider will process the claim. 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 $150 per calendar year. You must file a claim with EyeMed Vision Care to get reimbursed. Call Member Services for the claim form. 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. 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.
Welcome to Medicare preventive visit Our plan covers the one-time *Welcome to Medicare* preventive visit. The visit includes a review of your health, as well as education and counseling about preventive services you need	There is no coinsurance, copayment, or deductible for the *Welcome to Medicare* preventive visit.

Covered Service	What you pay
Welcome to Medicare preventive visit - continued (including certain screenings and shots (and vaccines)), and referrals for other care if needed. **Important:** We cover the *Welcome to Medicare* preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you want to schedule your *Welcome to Medicare* preventive visit.	
• Medicare-covered EKG following Welcome Visit Preventive Services	$0 copayment for each Medicare-covered service.
Wigs Wigs are covered for members who experience hair loss due to treatment for cancer. 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 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.	Plan covers up to $500 per calendar year. To access the wig benefit, you may purchase the wig from any provider. 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. Additionally, you have access to discounted rates if using a participating provider. Participating providers can be found in the *Provider Directory*. If you use a non-participating provider, you would need to pay out of pocket and submit for reimbursement. You must

Covered Service	What you pay
Wigs - continued	file a claim with the plan to get reimbursed. Call Member Services for the claim form. If the cost of the wig exceeds the benefit limit ($500), you are responsible for all additional charges. No referral is required for this benefit.

Section 2.1 Extra optional supplemental benefits you can buy

Our plan offers some extra benefits that aren't 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 certain 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 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**
Tufts Medicare Preferred Dental Option* *Cost-shares for these items/services do not count toward your annual maximum out-of-pocket amount.	You pay an additional monthly premium amount of $38.50.
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.	Cost-sharing information is provided below based on the class of dental services you receive.
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.	Refer to the following sections below for additional important information:

Optional Supplemental Benefit: Tufts Medicare Preferred Dental Option	**What you must pay when you get these services**
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 Dental Directory located at thpmp.org/dentist, or contact the Member Services number listed on the back cover of this document. Coordination of Benefits is used when you have more than one dental plan. These rules determine which plan pays first and which plan pays second. If this plan is your secondary plan, we may reduce our payment based on what your primary plan has already paid. Together, both plans will not pay more than the allowed cost of your covered dental service. Under the non-duplication of benefits provision, this plan may not pay any additional benefits if your primary plan has already paid the same amount or more than this plan would have paid as the primary plan.	**Pre-Treatment Estimates** for explanation of how to seek *Pre-Treatment Estimates* before receiving dental care. **Limitations and Exclusions** *for Limitations and Exclusions* that apply to the Tufts Medicare Preferred Dental Option described in this section.
Class 1 Diagnostic and Preventive Services Comprehensive Oral Exam (including the initial dental history and charting of teeth) covered once every 36 months Periodic Oral Evaluation covered twice per year. Intra oral bitewing X-rays images (X-rays of the crowns of the teeth) covered twice per year when oral conditions indicate need. Prophylaxis (routine cleaning, scaling and polishing of teeth) covered twice per year.	You pay $0 for Class 1 Diagnostic and Preventive Services.
Class 2 Basic Services Emergency oral evaluation problem focused exams covered once every 12 months. Intra oral X-ray image of the entire mouth (panoramic image) covered once every 60 months.	You pay 20% coinsurance for Class 2 Basic Services.

Optional Supplemental Benefit: Tufts Medicare Preferred Dental Option	What you must pay when you get these services
Intra oral X-ray image of the entire mouth (full mouth series) covered once every 60 months. Single tooth X-ray images covered as needed. Silver fillings and white fillings covered once every 24 months per surface, per tooth. Periodontal cleaning covered once every 6 months following active periodontal therapy, not to be combined with regular cleanings. Scaling and root planing covered once every 24 months, per quadrant. Scaling in presence of generalized moderate/severe gingival inflammation covered once every 24 months after oral evaluation and in lieu of a covered prophylaxis. Full mouth debridement covered once per lifetime. Simple extractions covered once per tooth. Minor treatment for pain relief covered only if no services other than exam and X-rays were performed on the same date of service.	
Class 3 Major Services Protective restorations are covered once per tooth. **Oral Surgery** Surgical extractions are covered once per tooth. **Periodontics** Periodontal surgery: One surgical procedure is covered per lifetime; gingivectomy or gingivoplasty and osseous surgery are covered as needed. Bone replacement grafts - retained natural tooth - first site in quadrant and each additional site in quadrant are covered once per lifetime. Guided tissue regeneration, natural teeth - resorbable barrier, per site and non-resorbable barrier, per site are covered once per lifetime.	You pay 50% coinsurance for Class 3 Major Services.

Optional Supplemental Benefit: Tufts Medicare Preferred Dental Option	What you must pay when you get these services
Endodontics Root canal treatment covered once per tooth per lifetime. Apicoectomy covered as needed. Retreatment root canal therapy covered once per tooth per lifetime at least 24 months after initial root canal therapy. **Prosthetic Maintenance** Bridge or denture repair covered once every 24 months per bridge or denture. Tissue conditioning covered one treatment per denture every 84 months. Adding teeth to existing partial or full dentures covered once per tooth, per denture per 24 months. Rebase or reline of dentures is covered once per denture every 24 months.	
Adjunctive Services (provided in conjunction with the primary treatment) 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. **Prosthodontics** Complete or partial dentures are covered one per arch within 84 months. Fixed bridges covered once per 84 months. **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. Temporary partial dentures covered once per 84 months (to replace any of the six upper or lower front teeth, but only if the temporary	You pay 50% coinsurance for Class 3 Major Services.

Optional Supplemental Benefit: Tufts Medicare Preferred Dental Option	What you must pay when you get these services
partial dentures are installed immediately following the loss of teeth during the period of healing). **Major Restorative (teeth must have good prognosis)** 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. Recement of crowns and onlays is covered once per tooth per 12 months. Inlays covered once per tooth per 84 months. 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.	

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 or by calling Member Services at 1-800-701-9000 (TTY: 711). To enroll by mail, download the enrollment form from our website www.thpmp.org/forms and follow the directions on the form.

Your dental premium must be paid the same way you pay your medical premium. Please refer to *Chapter 1, Section 5* in this *Evidence of Coverage* 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, 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 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 and occlusal guards - hard appliance full arch, soft appliance full arch or hard appliance partial arch (commonly referred to as a night guard or bite guard).
- 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 Services that aren't covered by our plan (exclusions)

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

The chart below lists services and items that either aren't 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 get the excluded services at an emergency facility, the excluded services are still not covered, and our plan won't 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 made to not cover a medical service, go to Chapter 7, Section 5.3.)

Services not covered by Medicare	Covered only under specific conditions
Acupuncture	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
Cosmetic surgery or procedures	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
Custodial care Custodial care is personal care that doesn't 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	Not covered under any condition
Experimental medical and surgical procedures, equipment, and medications Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community	May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan (Go to Chapter 3, Section 5 for more information on clinical research studies)
Extended care bed holds	Not covered under any condition

Services not covered by Medicare	Covered only under specific conditions
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
Home-delivered meals	Not covered under any condition
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 help, 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	Dental care required to treat illness or injury may be covered as inpatient or outpatient care Additional services may be covered if member elects to purchase the Tufts Medicare Preferred Dental Option.
Orthopedic shoes or supportive devices for the feet	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
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

Services not covered by Medicare	Covered only under specific conditions
Private room in a hospital	Covered only when medically necessary
Reversal of sterilization procedures and/or non-prescription contraceptive supplies	Not covered under any condition
Routine chiropractic care	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	Additional services may be covered if member elects to purchase the Tufts Medicare Preferred Dental Option.
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids	One pair of eyeglasses with frames (or one set of contact lenses) covered after each cataract surgery that implants an intraocular lens. 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 any provider.
Routine foot care	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	Routine hearing exam is covered once per calendar year. Hearing aid evaluation and fitting is covered with **TruHearing, Inc**. Providers. Coverage for prescription hearing aids includes up to 2 aids per year, 1 aid per ear, from **TruHearing, Inc.** providers only.

Services not covered by Medicare	Covered only under specific conditions
Services considered not reasonable and necessary, according to Original Medicare standards.	Not covered under any condition
Transportation, except by ambulance as described in this chapter, Section 2. 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	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.

CHAPTER 5:

Asking us to pay our share of a bill for covered medical services

SECTION 1 Situations when you should ask us to pay our share for covered services

Sometimes when you get medical care, you may need to pay the full cost. Other times, you may find you pay more than you expected under the coverage rules of our plan, or you may get a bill from a provider. In these cases, you can ask our plan to pay you back (reimburse you). It's your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services covered by our plan. There may be deadlines that you must meet to get paid back. Go to 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 got or for more than your share of cost sharing as discussed in this material. First try to resolve the bill with the provider. If that doesn't work, send the bill to us instead of paying it. We'll look at the bill and decide whether the services should be covered. If we decide they should be covered, we'll pay the provider directly. If we decide not to pay it, we'll 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.

Examples of situations in which you may need to ask our plan to pay you back or to pay a bill you got:

1. **When you've got emergency or urgently needed medical care from a provider who's not in our plan's network**

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

   - You're 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 get 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 made.
   - You may get a bill from the provider asking for payment you think you don't owe. Send us this bill, along with documentation of any payments you already made.
     - If the provider is owed anything, we'll pay the provider directly.

- If you already paid more than your share of the cost of the service, we'll determine how much you owed and pay you back for our share of the cost.

2. When a network provider sends you a bill you think you shouldn't pay

Network providers should always bill our 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.

- You only have to pay your cost-sharing amount when you get covered services. We don't 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's a dispute and we don't pay certain provider charges.
- Whenever you get a bill from a network provider you think is more than you should pay, send us the bill. We'll contact the provider directly and resolve the billing problem.
- If you already paid a bill to a network provider, but feel you paid too much, send us the bill along with documentation of any payment you made and ask us to pay you back the difference between the amount you paid and the amount you owed under our plan.

3. If you're retroactively enrolled in our plan

Sometimes a person's enrollment in our plan is retroactive. (This 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 covered services after your enrollment date, you can ask us to pay you back for our share of the costs. You need to submit paperwork such as receipts and bills for us to handle the reimbursement.

When you send us a request for payment, we'll review your request and decide whether the service or drug should be covered. This is called making a **coverage decision**. If we decide it should be covered, we'll pay for our share of the cost for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 7 has information about how to make an appeal.

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

You can ask 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've made. It's a good idea to make a copy of your bill and receipts for your records.

To make sure you're 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'll help us process the information faster.

- Download a copy of the form from our website (thpmp.org/forms) or call Member Services at 1-800-701-9000 (TTY users call 711) and ask for the form.

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

EyeMed Payment Requests:

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

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

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

- If we decide the medical care is covered and you followed all the rules, we'll pay for our share of the cost. If you already paid for the service, we'll mail your reimbursement of our share of the cost to you. If you haven't paid for the service yet, we'll mail the payment directly to the provider.
- If we decide the medical care is *not* covered, or you did *not* follow all the rules, we won't pay for our share of the cost. We'll send you a letter explaining the reasons why we aren't sending the payment and your rights to appeal that decision.

Section 3.1 If we tell you that we won't pay for all or part of the medical care or drug, you can make an appeal

If you think we made a mistake in turning down your request for payment or the amount we're paying, you can make an appeal. If you make an appeal, it means you're 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.

CHAPTER 6:

Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities

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

Our 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 our plan may meet these accessibility requirements include, but aren't 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, in large print, or other alternate formats at no cost if you need it. We're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, call Member Services at 1-800-701-9000 (TTY users call 711).

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

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with our Civil Rights Coordinator (contact information can be found in Chapter 9, Section 5). You can also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights by calling 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 al 1-800-701-9000 (los usuarios de TTY deben llamar al 711).

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 you get timely access to covered services

You have the right to choose a primary care provider (PCP) in our 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 our 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.

If you think you aren't 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've given legal power to make decisions for you first.*
- There are certain exceptions that don't require us to get your written permission first. These exceptions are allowed or required by law.
    - We're required to release health information to government agencies that are checking on quality of care.
    - Because you're a member of our plan through Medicare, we're 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's been shared with others

You have the right to look at your medical records held by our plan, and to get a copy of your records. We're 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'll 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 aren't routine.

If you have questions or concerns about the privacy of your personal health information, call Member Services at 1-800-701-9000 (TTY users call 711).

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

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

If you want any of the following kinds of information, call Member Services at 1-800-701-9000 (TTY users call 711):

- **Information about our plan.** This includes, for example, information about our 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 isn't 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 You have the right to know your treatment options and participate in decisions about your 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 your choices.** You have the right to be told about all treatment options recommended for your condition, no matter what they cost or whether they're 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. 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's to be done if you can't 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're in this situation. This means, *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.

Legal documents you can use to give directions in advance in these situations are called **advance directives.** Documents like a **living will** and **power of attorney for health care** are examples of advance directives.

How to set up an advance directive to give instructions:

- **Get a form.** You can get an advance directive form from your lawyer, a social worker, or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also call Member Services at 1-800-701-9000 (TTY users call 711) to ask for the forms.
- **Fill out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to the right people**. Give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

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

- The hospital will ask whether you signed an advance directive form and whether you have it with you.
- If you didn't sign an advance directive form, the hospital has forms available and will ask if you want to sign one.

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

If your instructions aren't followed

If you sign an advance directive and you believe that a doctor or hospital didn't follow the instructions in it, you can file a complaint with Acentra Health at 1-888-319-8452 (TTY: 711).

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

If you have any problems, concerns, or complaints and need to ask for 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're required to treat you fairly.**

Section 1.7 If you believe you're being treated unfairly, or your rights aren't being respected

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

If you believe you've been treated unfairly or your rights haven't been respected *and* it's *not* about discrimination, you can get help dealing with the problem you're having from these places:

- **Call Member Services at 1-800-701-9000 (TTY users call 711)**
- **Call your local SHIP** at 1-800-243-4636
- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

Section 1.8 How to get more information about your rights

Get more information about your rights from these places:

- **Call Member Services at 1-800-701-9000 (TTY users call 711)**
- **Call your local SHIP** at 1-800-243-4636
- **Contact Medicare**
  - Visit Medicare.gov to read the publication *Medicare Rights & Protections*. (available at: https://www.medicare.gov/publications/11534-medicare-rights-and-protections.pdf)
  - Call 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

SECTION 2 Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. For questions, call Member Services at 1-800-701-9000 (TTY users call 711).

- **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's covered and the rules you need to follow to get covered services.
  - Chapters 3 and 4 give details about medical services.
- **If you have any other health coverage in addition to our plan, or separate prescription drug coverage, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you're enrolled in our plan.** Show our plan membership card whenever you get 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 you and your doctors agree on.
  - Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect 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're responsible for these payments:
  - You must pay your plan premiums.
  - You must continue to pay your premium for your Medicare Part B to stay a member of our plan.
  - For some of your medical services covered by our 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* our plan service area, you can't stay a member of our plan.**
- **If you move, tell Social Security (or the Railroad Retirement Board).**

CHAPTER 7:

If you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 What to do if you have a problem or concern

This chapter explains 2 types of processes for handling problems and concerns:

- For some problems, you need to use the **process for coverage decisions and appeals.**
- For other problems, you need to use the **process for making complaints** (also called grievances).

Both 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 information in this chapter will help you identify the right process to use and what to do.

Section 1.1 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. To make things easier, this chapter uses more familiar words in place of some legal terms.

However, it's sometimes important to know the correct legal terms. To help you know which terms to use to get the right help or information, we include these legal terms when we give details for handling specific situations.

SECTION 2 Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Member Services at 1-800-701-9000 (TTY users call 711) for help. In some situations, you may also want help or guidance from someone who isn't connected with us. Two organizations that can help you are:

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're having. They can also answer 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 for help.

- Call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048
- Visit Medicare.gov

SECTION 3 Which process to use for your problem

Is your problem or concern about your benefits or coverage?

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

Yes.

Go to **Section 4, A guide to coverage decisions and appeals.**

No.

Go to **Section 9, 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 coverage decisions and appeals

Coverage decisions and appeals deal with problems about your benefits and coverage for your medical care (services, items, and Part B drugs, including payment). To keep things simple, we generally refer to medical items, services, and Medicare Part B drugs as **medical care**. You may 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 before you get services

If you want to know if we'll cover medical care before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical care. For example, if our plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either you or your network doctor can show that you got 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'll cover a particular medical service or refuses to provide medical care you think you need.

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'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we might decide medical care isn't covered or is no longer covered 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 you get a benefit, and you aren't satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we made. Under certain circumstances, you can ask for 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 properly followed the rules. When we complete 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'll 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 not connected to us.

- You don't 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 don't fully agree with your Level 1 appeal.
- Go to **Section 5.4** for more information about Level 2 appeals for medical care.

If you aren't satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.1 Get help 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:

- **Call Member Services at 1-800-701-9000 (TTY users call 711)**
- **Get free help** from your State Health Insurance Program.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they need to be appointed as your representative. Call Member Services at 1-800-701-9000 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at tuftsmedicarepreferred.org/forms.)
    - For medical care or Part B drugs, your doctor can ask for 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.
- **You can ask someone to act on your behalf.** 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 at 1-800-701-9000 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at tuftsmedicarepreferred.org/forms.) This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.
    - We can accept an appeal request from a representative without the form, but we can't complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll 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 can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.2 Rules and deadlines for different situations

There are 3 different situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give the details for each of these situations:

- **Section 5:** Medical care: How to ask for a coverage decision or make an appeal
- **Section 6:** How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon
- **Section 7:** 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 information applies to you, call Member Services at 1-800-701-9000 (TTY users call 711). You can also get help or information from your SHIP.

SECTION 5 Medical care: How to ask for a coverage decision or make an appeal

Section 5.1 What to do if you have problems getting coverage for medical care or want us to pay you back for our share of the cost of your care

Your benefits for medical care are described in Chapter 4 in the Medical Benefits Chart. In some cases, different rules apply to a request for a Part B drug. In those cases, we'll explain how the rules for Part B drugs are different from the rules for medical items and services.

This section tells what you can do if you're in any of the 5 following situations:

1. You aren't getting certain medical care you want, and you believe this is covered by our plan. **Ask for a coverage decision. Section 5.2.**
2. Our plan won't approve the medical care your doctor or other medical provider wants to give you, and you believe this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**
3. You got medical care that you believe should be covered by our plan, but we said we won't pay for this care. **Make an Appeal. Section 5.3.**
4. You got and paid for medical care that you believe should be covered by our plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5**
5. You're being told that coverage for certain medical care you've 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, go to Sections 6 and 7 of this chapter. Special rules apply to these types of care.

Section 5.2 How to ask for a coverage decision

Legal Terms:

A coverage decision that involves your medical care 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 7 calendar days when the medical item or service is subject to our prior authorization rules, 14 calendar days for all other medical items and services, 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. To get a fast coverage decision, you must meet 2 requirements:

- You may *only ask* for coverage for medical care items and/or services (not requests for payment for items and/or services you already got).
- 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 regain function.

If your doctor tells us that your health requires a fast coverage decision, we'll 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'll decide whether your health requires that we give you a fast coverage decision. If we don't approve a fast coverage decision, we'll send you a letter that:

- Explains that we'll use the standard deadlines.
- Explains if your doctor asks for the fast coverage decision, we'll 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 asked for.

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'll give you an answer within 7 calendar days after we get your request for a medical item or service that is subject to our prior authorization rules. If your requested medical item or service is not subject to our prior authorization rules, we'll give you an answer within 14 calendar days after we get your request. If your request is for a Part B drug, we'll give you an answer within 72 hours after we get 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'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. We'll 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. Go to Section 9 for information on complaints.)

For fast Coverage decisions, we use an expedited timeframe.

A fast coverage decision means we'll answer within 72 hours if your request is for a medical item or service. If your request is for a Part B drug, we'll 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'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. (Go to Section 9 of this chapter for information on complaints.) We'll call you as soon as we make the decision.
- If our answer is no to part or all of what you asked for, we'll 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're going on to Level 1 of the appeals process.

Section 5.3 How to make a Level 1 appeal

Legal Terms:

An appeal to our 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're appealing a decision we made about coverage for care, you and/or your doctor need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we'll 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're asking for a standard appeal, submit your standard appeal in writing.** You may also ask for an appeal by calling us. Chapter 2 has contact information.
- **If you're 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 asking for 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.
- We'll gather more information if needed and may contact you or your doctor.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.
    - 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'll tell you in writing. We can't take extra time if your request is for a Part B drug.
    - If we don't give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we're required to automatically send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. The independent review organization will notify you in writing when it gets your appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for,** we'll 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 gets your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we get your appeal. We'll 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'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
    - If you believe we shouldn't take extra days, you can file a *fast complaint*. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (Go to Section 9 for information on complaints.)
    - If we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal, where an independent review organization will review the appeal. The independent review organization will notify you in writing when it gets your appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** 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 Part B drug.

- **If our plan says no to part or all of your appeal,** we'll automatically send your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

Section 5.4 The Level 2 appeal process

Legal Term:

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

The **independent review organization is an independent organization hired by Medicare**. It isn't connected with us and isn't 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'll 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 the information related to your appeal.

If you had a fast appeal at Level 1, you'll also have a fast appeal at Level 2.

- For the fast appeal, the independent review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it gets your appeal.
- 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**. If they take extra days, they will notify you in writing. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

If you had a standard appeal at Level 1, you'll also have a standard appeal at Level 2.

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

take extra days, they will notify you in writing. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

Step 2: The independent review organization gives you its answer.

The independent review organization will tell you its decision in writing and explain the reasons for it.

- **If the independent 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 get the decision from the independent review organization for **standard requests**. For **expedited requests**, we have **72 hours** from the date we get the decision from the independent review organization.
- **If the independent review organization says yes to part or all of a request for a Part B drug**, we must authorize or provide the Part B drug within **72 hours** after we get the decision from the independent review organization for **standard requests**. For **expedited requests,** we have **24 hours** from the date we get the decision from the independent 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 shouldn't 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 that:
  - Explains the decision.
  - Lets you know about your 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.
  - Tells 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 3 additional levels in the appeals process after Level 2 (for a total of 5 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 explains the Level 3, 4, and 5 appeals processes.

Section 5.5 If you're asking us to pay for our share of a bill you got for medical care

Chapter 5 describes when you may need to ask for reimbursement or to pay a bill you have got 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're asking for a coverage decision. To make this decision, we'll check to see if the medical care you paid for is covered. We'll also check to see if you followed 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 the rules, we'll send you the payment for our share of the cost typically within 30 calendar days, but no later than 60 calendar days after we get your request. If you haven't paid for the medical care, we'll 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 won't send payment. Instead, we'll send you a letter that says we won't pay for the medical care and the reasons why.

If you don't agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you're 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 in Section 5.3. For appeals concerning reimbursement, note:

- We must give you our answer within 60 calendar days after we get your appeal. If you're asking us to pay you back for medical care you already got and paid for, you aren't 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 asked for to you or the provider within 60 calendar days.

SECTION 6 How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon

When you're admitted to a hospital, you have the right to get all covered hospital services necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day you leave the hospital. They'll 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're 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'll get a written notice from Medicare that tells you about your rights

Within 2 calendar days of being admitted to the hospital, you'll 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 don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Member Services at 1-800-701-9000 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048).

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you:
    - Your right to get 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 quality of your hospital care.
    - Your right to **request an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date, so we'll cover your hospital care for a longer time.
2. **You'll be asked to sign the written notice to show that you got 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 got the information about your rights. The notice doesn't give your discharge date. Signing the notice **doesn't mean** you're agreeing on a discharge date.
3. **Keep your copy** of the notice so you 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 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.
    - To look at a copy of this notice in advance, call Member Services at 1-800-701-9000 (TTY users call 711) or 1-800 MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can also get the notice online at CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Section 6.2 How to make a Level 1 appeal to change your hospital discharge date

To ask us to cover your inpatient hospital services for a longer time, 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, call Member Services at 1-800-701-9000 (TTY users call 711). Or call your State Health Insurance Program (SHIP) for personalized help. SHIP contact information is available in Chapter 2, Section 3.

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 who are 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 aren't 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 got (*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.**
    - **If you meet this deadline**, you can 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 don't meet this deadline, contact us.** If you decide to stay in the hospital after your planned discharge date, *you may have to pay all the costs* for hospital care you get after your planned discharge date.
- Once you ask for an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we're contacted, we'll 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's 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 at 1-800-701-9000 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227) (TTY users call

1-877-486-2048.) Or you can get a sample notice online at CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

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 can if you want.
- The reviewers will also look at your medical information, talk with your doctor, and review information that we and the hospital gave them.
- By noon of the day after the reviewers told us of your appeal, you'll 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's 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 independent review organization says *yes*, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You'll 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.

What happens if the answer is no?

- If the independent review organization says *no*, they're 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 independent review organization says *no* to your appeal and you decide to stay in the hospital, **you may have to pay the full cost** of hospital care you get 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 said *no* to your appeal, *and* you stay in the hospital after your planned discharge date, you can make another appeal. Making another appeal means you're going to *Level 2* of the appeals process.

Section 6.3 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 its 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 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 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 independent review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you got since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it's medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

If the independent review organization says no:

- It means they agree with the decision they made on your Level 1 appeal. This is called upholding the decision.
- The notice you get will tell you in writing what you can do if you want to continue with the review process.

Step 4: If the answer is no, you need to decide whether you want to take your appeal further by going to Level 3

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 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

When you're 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's time to stop covering any of these 3 types of care for you, we're required to tell you in advance. When your coverage for that care ends, *we'll stop paying our share of the cost for your care*.

If you think we're ending the coverage of your care too soon, you can appeal our decision. This section tells you how to ask for an appeal.

Section 7.1 We'll tell you in advance when your coverage will be ending

Legal Term:

Notice of Medicare Non-Coverage. It tells you how you can ask for a **fast-track appeal.** Asking for a fast-track appeal is a formal, legal way to ask for a change to our coverage decision about when to stop your care.

1. **You get a notice in writing** at least 2 calendar days before our plan is going to stop covering your care. The notice tells you:
   - The date when we'll stop covering the care for you.
   - How to request a fast track appeal to ask 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 got it.** Signing the notice shows *only* that you got the information about when your coverage will stop. **Signing it doesn't mean you agree** with our plan's decision to stop care.

Section 7.2 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'll 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, call Member Services at 1-800-701-9000 (TTY users call 711). Or call your State Health Insurance Program (SHIP) for personalized help. SHIP contact information is available in Chapter 2, Section 3.

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 who are 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 aren't part of our plan.

Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a *fast-track appeal*. You must act quickly.

How can you contact this organization?

- The written notice you got (*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 want to file an appeal, you still have appeal rights. Contact the Quality Improvement Organization using the contact information on the Notice of Medicare Non-coverage. The name, address, and phone number of the Quality Improvement Organization for your state may also be found in Chapter 2.

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

Legal Term:

Detailed Explanation of Non-Coverage. Notice that gives 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 can if you want.
- The independent review organization will also look at your medical information, talk with your doctor, and review information our plan gives them.

- By the end of the day the reviewers tell us of your appeal, you'll 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's medically necessary.**
- You'll 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 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, **you'll 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 7.3 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 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 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 independent review organization says yes?

- **We must reimburse you** for our share of the costs of care you got since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it's medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the independent 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 want to continue with the review process. It will give you details about how to go 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 need to decide whether you want to take your appeal further.

- There are 3 additional levels of appeal after Level 2, (for a total of 5 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 Levels 3, 4 and 5

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

This section may be right for you if you made a Level 1 appeal and a Level 2 appeal, and both of your appeals were turned down.

If the dollar value of the item or medical service you 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 can't appeal any further. The written response you get to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first two levels. Here's who handles the review of your appeal at each of these levels.

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's 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 we get the Administrative Law Judge's or attorney adjudicator's decision.
    - If we decide to appeal the decision, we'll 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 the decision that turns down your appeal, the appeals process is over.
    - If you don't 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'll 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 getting the Council's decision.
    - If we decide to appeal the decision, we'll 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.

- If you don't 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 to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal

A judge at the **Federal District Cour**t will review your appeal.

- A judge will review all 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 customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you got (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Member Services? • Do you feel you're being encouraged to leave our plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Services or other staff at our plan?

Complaint	Example
	○ Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all about the *timeliness* of our actions related to coverage decisions and appeals)	If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a *fast coverage decision* or a *fast appeal*, and we said no; you can make a complaint. • You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we aren't meeting deadlines for covering or reimbursing you for certain medical items or services or drugs 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 called **filing a grievance.**

Using the process for complaints is called **using the process for filing a grievance.**

A **fast complaint** is called an **expedited grievance.**

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

- **Calling Member Services at 1-800-701-9000 (TTY users call 711) is usually the first step.** If there's anything else you need to do, Member Services will let you know.
- **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll 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 CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at 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'll 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 days** (44 calendar days total) to answer your complaint. If we decide to take extra days, we'll tell you in writing.
- **If you're making a complaint because we denied your request for a fast coverage decision or a fast appeal, we'll automatically give you a fast complaint.** If you have a fast complaint, it means we'll give you **an answer within 24 hours.**
- **If we don't agree** with some or all of your complaint or don't take responsibility for the problem you're complaining about, we'll include our reasons in our response to you.

Section 9.3 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care,* you have 2 extra options:

- **You can make your complaint directly 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 9.4 You can also tell Medicare about your complaint

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

CHAPTER 8:

Ending membership in our plan

SECTION 1 Ending your membership in our plan

Ending your membership in Tufts Medicare Preferred HMO Prime No Rx (HMO) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you decide you *want* to leave. Sections 2 and 3 give information on ending your membership voluntarily.
- There are also limited situations where we're required to end your membership. Section 5 tells you about situations when we must end your membership.

If you're leaving our plan, our plan must continue to provide your medical care, and you'll 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 Open Enrollment Period

You can end your membership in our plan during the **Open Enrollment Period** each year. During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- The **Open 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 coverage:
  - Another Medicare health plan, with or without drug coverage,
  - Original Medicare *with* a separate Medicare drug plan,
  - Original Medicare *without* a separate Medicare drug plan.
- **Your membership will end in our plan** when your new plan's coverage starts on January 1.

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

You can make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period** each year.

- **The Medicare Advantage Open Enrollment Period** is from January 1 to March 31 and, for new Medicare enrollees 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 Medicare Advantage Open Enrollment Period,** you can:
  - Switch to another Medicare Advantage Plan with or without drug coverage.
  - Disenroll from our plan and get coverage through Original Medicare. If you switch to Original Medicare during this period, you can also join a separate Medicare drug plan at the same 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 drug plan, your membership in the drug plan will start 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 Prime No Rx (HMO) 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. These are just examples. For the full list you can contact our plan, call Medicare, or visit Medicare.gov.

- Usually, when you move
- If you have Medicaid (MassHealth)
- If we violate our contract with you
- If you're getting 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).

Enrollment time periods vary depending on your situation.

To find out if you're eligible for a Special Enrollment Period, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. If you're 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 drug coverage.
- Original Medicare *with* a separate Medicare drug plan.
- Original Medicare *without* a separate Medicare drug plan.

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

Section 2.4 Get more information about when you can end your membership

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

- **Call Member Services at 1-800-701-9000 (TTY users call 711)**
- Find the information in the ***Medicare & You 2027*** handbook
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048

SECTION 3 How to end your membership in our plan

The table below explains how you can end your membership in our plan.

To switch from our plan to:	Here's what to do:
Another Medicare health plan	• Enroll in the new Medicare health plan. • You'll automatically be disenrolled from Tufts Medicare Preferred HMO Prime No Rx (HMO) when your new plan's coverage starts.
Original Medicare *with* a separate Medicare drug plan	• Enroll in the new Medicare drug plan. • You'll automatically be disenrolled from Tufts Medicare Preferred HMO Prime No Rx (HMO) when your new plan's coverage starts.
Original Medicare *without* a separate Medicare drug plan	• **Send us a written request to disenroll** or download the disenrollment form from our website at tuftsmedicarepreferred.org/hmo-ppo-disenrollment-form and mail the completed form to the address provided on the form. Call Member

To switch from our plan to:	Here's what to do:
	Services at 1-800-701-9000 (TTY users call 711) if you need more information on how to do this. • You can also call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users call 1-877-486-2048. • You'll be disenrolled from Tufts Medicare Preferred HMO Prime No Rx (HMO) when your coverage in Original Medicare starts.

Note: If you also have creditable prescription drug coverage (e.g., a separate Medicare drug plan) 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 and services through our plan

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

- **Continue to use our network providers to get medical care.**
- **If you're hospitalized on the day your membership ends, your hospital stay will be covered by our plan until you're discharged** (even if you're discharged after your new health coverage starts).

SECTION 5 Tufts Medicare Preferred HMO Prime No Rx (HMO) must end your plan membership in certain situations

Tufts Medicare Preferred HMO Prime No Rx (HMO) must end your membership in our 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're away from our service area for more than 6 months

- If you move or take a long trip, call Member Services to find out if the place you're moving or traveling to is in our plan's area

- If you become incarcerated (go to prison)
- If you're no longer a United States citizen or national, or eligible noncitizen
- If you intentionally give us incorrect information when you're enrolling in our plan, and that information affects your eligibility for our plan (We can't make you leave our plan for this reason unless we get permission from Medicare first)
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan (We can't 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 can't 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 don't pay your plan premiums for *2 months*
  - We must notify you in writing that you have *2 months* to pay your plan premium before we end your membership

If you have questions or want more information on when we can end your membership, call Member Services at 1-800-701-9000 (TTY users call 711).

Section 5.1 We <u>can't</u> ask you to leave our plan for any health-related reason

Tufts Medicare Preferred HMO Prime No Rx (HMO) isn't allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel you're being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 5.2 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, (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 aren't included or explained in this document.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, age, 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, 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 HHS.gov/ocr/index.html.

If you have a disability and need help with access to care, call Member Services at 1-800-701-9000 (TTY users call 711). 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 Prime No Rx (HMO), 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 Prime No Rx (HMO) and providers

Tufts Medicare Preferred HMO Prime No Rx (HMO) provides coverage for health care services. Tufts Medicare Preferred HMO Prime No Rx (HMO) does not provide health care services. Tufts Medicare Preferred HMO Prime No Rx (HMO) 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 Prime No Rx (HMO) employees, or representatives. Providers are not authorized to change this *Evidence of Coverage* or assume or create any obligation for Tufts Medicare Preferred HMO Prime No Rx (HMO) 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 Legal Coordinator
1 Wellness Way
Canton, MA 02021
Phone: 1-888-880-8699 ext. 48000

TTY number: 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/smartscreen/main.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

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 doesn't exceed 24 hours.

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

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than our plan's allowed cost-sharing amount. As a member of Tufts Medicare Preferred HMO Prime No Rx (HMO), you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We don't allow providers to **balance bill** or otherwise charge you more than the amount of cost sharing our 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 haven't gotten 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-SNP) – C-SNPs are SNPs that restrict enrollment to MA eligible people who have specific severe and chronic diseases.

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 about quality of care, waiting times, and the customer service you get. It also includes complaints if our plan doesn't 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 or hospital outpatient visit. 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 gotten. (This is in addition to our plan's monthly plan premium.) Cost sharing includes any combination of the following 3 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 gotten; or 3) any coinsurance amount, a percentage of the total amount paid for a service, that a plan requires when a specific service is gotten.

Covered Services – The term we use to mean all 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 don't need skilled medical care or skilled nursing care. Custodial care, provided by people who don't 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 people 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 person's eligibility.

Dually Eligible Individual – A person who is eligible for Medicare and Medicaid coverage.

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're 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 doesn't involve coverage or payment disputes.

Home Health Aide – A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

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. Our plan must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums, you're still a member of our plan. You can still get all medically necessary services as well as the supplemental benefits we offer.

Hospital Inpatient Stay – A hospital stay when you've 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're 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 3 months before the month you turn 65, includes the month you turn 65, and ends 3 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 Medicare premiums don't count toward the maximum out-of-pocket amount.

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 get 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 a person 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, 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 Prime No Rx (HMO) doesn't offer Medicare prescription drug coverage.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all the services that are covered by Medicare Part A and B. The term Medicare-Covered Services doesn't 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 our 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.

Open 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.

Optional Supplemental Benefits – Non-Medicare-covered benefits that can be purchased for an additional premium and aren't 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 2 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 doesn't have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that aren't employed, owned, or operated by our plan.

Out-of-Pocket Costs – Go to the definition for cost sharing above. A member's cost-sharing requirement to pay for a portion of services gotten 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 get both their Medicare and Medicaid benefits through our plan.

Part C – Go to 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're received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are gotten from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined

out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Preventive services – Health care services that help you stay healthy, detect health problems early, determine the most effective treatments, and prevent certain diseases. Preventive services include exams, shots, lab tests, and screenings. They also include programs for health monitoring, and counseling and education to help you take care of your own health.

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 based on specific criteria. Covered services that need prior authorization are marked in the Medical 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 – A written order from your primary care doctor for you to visit a specialist or get certain medical services. Without a referral, our plan may not pay for services from a specialist.

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 inpatient rehabilitation care, physical therapy (outpatient), 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. Our plan must disenroll you if you permanently move out of our 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 plan 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 live 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 aren't the same as Social Security benefits.

Urgently Needed Services – A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

TUFTS Health Plan

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, Member Services
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.

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TUFTS Health Plan

a Point32Health company

Form Approved
OMB# 0938-1421

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

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-701-9000 (HMO)/1-866-623-0172 (PPO). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-701-9000 (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ございます。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, MA 02021
WEBSITE	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	mass.gov/health-insurance-counseling

TUFTS Health Plan

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