TUFTS HEALTH PLAN MEDICARE PREFERRED

Medicare Supplement Policy

Tufts Medicare Preferred Supplement Core Plan

IMPORTANT NOTES ABOUT THIS POLICY

Right to Return Policy

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

Right to Continue Coverage

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

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

Our Right to Change Your Benefits or Premiums

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

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

TUFTS Health Plan

705 Mount Auburn Street, Watertown, MA 02472-1508

72-MS-CORE-POLICY-19

P-MAMS-CORE-001 Ed. 1-2019.

Tufts Health Plan Medicare Preferred Address And Telephone Directory

TUFTS HEALTH PLAN MEDICARE PREFERRED

705 Mount Auburn Street
Watertown, Massachusetts 02472-1508.

Hours: Representatives are available Monday – Friday, 8:00 a.m. – 8:00 p.m.
(From October 1 – March 31, representatives are available 7 days a week, 8:00 a.m. – 8:00 p.m.) After hours and on holidays, please leave a message and a representative will return your call the next business day.

IMPORTANT PHONE NUMBERS

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

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

Medicare:
Contact your local Social Security office or visit the website at: www.medicare.gov.

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

Services for Hearing-Impaired Members:
If you are hearing-impaired, the following services are provided:

Telecommunications Device for the Deaf (TTY):
If you have access to a TTY phone, call: 711. You will reach Customer Relations.

Massachusetts Relay (MassRelay):
711.

IMPORTANT ADDRESSES

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

Tufts Health Plan Medicare Preferred
Attn: Appeals and Grievances Department
705 Mount Auburn Street
P.O. Box 9181
Watertown, MA 02471-9183
Fax: 617-972-9509

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

Tufts Health Plan Medicare Preferred Address And Telephone Directory

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-701-9000 (TTY: 711).

Arabic: ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-701-9000 (رقم هاتف الصم والبكم: 711).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-701-9000 (TTY: 711)。

Farsi: توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
1-800-701-9000 (TTY: 711) فراهم می باشد. با تماس بگیرید.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-701-9000 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-701-9000 (TTY: 711).

Greek: ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-701-9000 (TTY: 711).

Gujarati: સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-701-9000 (TTY: 711).

Haitian Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-701-9000 (TTY: 711).

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-701-9000 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
1-800-701-9000 (TTY: 711）まで、お電話にてご連絡ください。

Khmer (Cambodian): ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-701-9000 (TTY: 711)

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-800-701-9000 (TTY: 711) 번으로 전화해 주십시오.

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-701-9000 (TTY: 711).

Navajo: Díí baa akó nínízin: Díí saad bee yáníltí'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, koji' hódíílnih 1-800-701-9000 (TTY: 711).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej.
Zadzwoń pod numer 1-800-701-9000 (TTY: 711).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis.
Ligue para 1-800-701-9000 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-701-9000 (TTY: 711).

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
Llame al 1-800-701-9000 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-701-9000 (TTY: 711).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.
Gọi số 1-800-701-9000 (TTY: 711).

Fraud, Waste and Abuse

You may have concerns about being billed for services you never received, or that your insurance information has been stolen or used by someone else. To report potential health care fraud or abuse, or if you have questions, please call us at 1-800-701-9000, or email fraudandabuse@tufts-health.com. You can also call our confidential hotline any time at 877-824-7123 or send an anonymous letter to us at:

Tufts Health Plan
Attn: Fraud and Abuse
705 Mount Auburn Street
Watertown, MA 02472

Table of Contents

Chapter 1: How Your Plan Works

OVERVIEW

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

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

Under the Plan, coverage is also provided for certain services which are not covered under Medicare. Covered services, cost sharing, limitations and exclusions are described in Chapter 3: Benefit Schedule and Covered Services.

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

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

- Eligible for coverage under Medicare; or
- Eligible for coverage under the Plan, when medically necessary.

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

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

- By contacting your local Social Security office; or
- Via the Internet on the official Medicare website at www.medicare.gov.

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

Note that words with special meanings are defined in the Glossary in Appendix A.

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

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

Canceling Appointments:
If you must cancel an appointment with any Provider:

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

MEMBER IDENTIFICATION CARD

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

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

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

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

- Carry your card at all times;
- Have your card with you for medical, hospital and other appointments; and
- Show your card to any Provider before you receive health care.

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

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

WHEN YOU NEED EMERGENCY CARE

Guidelines for Receiving Covered Emergency Care:
Follow these guidelines when you need emergency care within the United States.

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

INFORMATION RESOURCES FOR MEMBERS

Obtaining information about Tufts Health Plan Medicare Preferred:

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

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

How to Obtain This Information:

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

- Call 1-800-436-7757.
- Write a letter to the office. Address it to
  Health Policy Commissioner
  Office of Patient Protection
  50 Milk Street, 8th Floor
  Boston, MA 02109
- Send a fax to the office at 1-617-624-5046.
- Send an email to the office at HPC-OPP@state.ma.us.
- View information at the office's website. Go to www.mass.gov/anf/budget-taxes-and procurement/oversight-agencies/health-policy-commission/patient-protection.

ELIGIBILITY

Eligibility Rules:

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

- You are eligible for Medicare Parts A and B and are enrolled in Medicare Part B as either:
  - A person who is age 65 or older; or
  - A person who is disabled*, under age 65, and receiving Social Security disability benefits.
    *Note: If you are under age 65, you may enroll in this plan only if the disability that made you eligible for Medicare is a condition other than end-stage renal disease.
  - You are not enrolled in any other individual Medicare supplement plan.

Proof of Eligibility:

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

- Residence
- Medicare enrollment

Effective Date of Coverage:

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

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

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

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

Ambulance Services		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
Medicare benefits in full, except: • The Part B Deductible; • The Part B Coinsurance.	• The Part B Coinsurance.	• The Part B Deductible.
Tufts Medicare Preferred Supplement Core Covered Services		
Once Medicare provides coverage, Tufts Health Plan Medicare Preferred Medicare Supplement provides coverage up to the allowed charge for: • Medicare-approved transportation in an ambulance to an emergency medical facility for treatment of an accident or for emergency medical care. • Other medically necessary ambulance transportation approved by Medicare.		

**Benefits for covered services are provided based on the allowed charge. You may have to pay any amount over the allowed charge.*

Autism Spectrum Disorders – Diagnosis and Treatment		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
When covered by Medicare, Medicare benefits in full, except: • The Part B Deductible; • The Part B Coinsurance. When not covered by Medicare: Nothing.	For rehabilitative or habilitative care (including applied behavioral analysis): When covered by Medicare: • The Part B Coinsurance. When not covered by Medicare: • Benefits in full. For prescription medications: • Nothing. You must have Medicare Part D coverage. For psychiatric and psychological care: See Treatment for Biologically-based Mental Disorders later in this section. Therapeutic care: See Short-Term Rehabilitation Therapy (Physical, Occupational & Speech-Language) later in this section.	When covered by Medicare: • The Part B Deductible. When not covered by Medicare: • Nothing, for rehabilitative or habilitative care. • All charges for all other services.
Tufts Medicare Preferred Supplement Core Covered Services		
Coverage is provided, in accordance with Massachusetts law, for the diagnosis and treatment of autism spectrum disorders. Autism spectrum disorders include any of the pervasive developmental disorders, as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, and include: • Autistic disorder • Asperger's disorder and • Pervasive developmental disorders not otherwise specified. Coverage is provided, up the allowed charge, for the following covered services: • Habilitative or rehabilitative care, which are professional, counseling, and guidance services and treatment programs that are necessary to develop, maintain, and restore the functioning of the individual. These programs may include, but are not limited to, applied behavioral analysis (ABA) supervised by a board-certified behavior analyst (BCBA). For more information about these programs, call the Tufts Health Plan Mental Health Department at 1-800-208-9565; • Services provided by licensed or certified speech therapists, occupational therapists, physical therapists, or social workers; • Psychiatric and psychological care, covered under your mental health and substance abuse benefit, as a biologically-based mental disorder; and • Therapeutic care (including services provided by licensed or certified speech therapists, occupational therapists, physical therapists, or social workers), covered under your short-term rehabilitation therapy benefit.		

**Benefits for covered services are provided based on the allowed charge. You may have to pay any amount over the allowed charge.*

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

Blood Services – Inpatient		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
Medicare benefits in full, except: • The blood deductible. This deductible is for the first three pints of un-replaced blood during a calendar year.	• The blood deductible.	• Nothing.
Tufts Medicare Preferred Supplement Core Covered Services		
The Plan provides coverage for the inpatient blood deductible under Medicare Part A. This deductible is the cost of the first three pints of blood you use in a calendar year as an inpatient in a hospital or skilled nursing facility (SNF). **Note:** The inpatient blood deductible will apply to you only if the hospital or SNF has to purchase the blood for you for your inpatient admission. In this case, this deductible will be waived if you either replace the blood yourself or have it donated by another party. See also Blood Services – Outpatient. You are responsible only for paying one blood deductible under Medicare Part A or Part B per calendar year.		

**Benefits for covered services are provided based on the allowed charge. You may have to pay any amount over the allowed charge.*

Blood Services – Outpatient		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
Medicare benefits in full, except; • The blood deductible.	• The blood deductible.	• Nothing.
Tufts Medicare Preferred Supplement Core Covered Services		
The Plan provides coverage for the outpatient blood deductible under Medicare Part B. This deductible is the cost of the first three pints of blood you use in a calendar year as an outpatient in a hospital. **Note:** The outpatient blood deductible will apply to you only if the hospital has to purchase the blood for you for your outpatient services. In this case, this deductible will be waived if you either replace the blood yourself or have it donated by another party. See also Blood Services – Inpatient. You are responsible for only paying one blood deductible under Medicare Part A or Part B per calendar year.		

Cardiac Rehabilitation Services		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
Medicare benefits in full, except: • The Part B Deductible; • The Part B Coinsurance.	• The Part B Coinsurance.	• The Part B Deductible.
Tufts Medicare Preferred Supplement Core Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the allowed charge for Medicare-approved outpatient cardiac rehabilitation services.		

**Benefits for covered services are provided based on the allowed charge. You may have to pay any amount over the allowed charge.*

Chemotherapy		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
Medicare benefits on an inpatient basis as described under Hospital Medical and Surgical Care—Inpatient. Medicare benefits on an outpatient basis as described under Hospital Medical and Surgical Care—Outpatient.	As described under Hospital Medical and Surgical Care—Inpatient. As described under Hospital Medical and Surgical Care—Outpatient.	As described under Hospital Medical and Surgical Care—Inpatient. As described under Hospital Medical and Surgical Care—Outpatient.
Tufts Medicare Preferred Supplement Core Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the allowed charge for Inpatient and Outpatient chemotherapy for cancer patients.		

Chiropractor Services		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
Medicare benefits in full, except: • The Part B Deductible; • The Part B Coinsurance.	• The Part B Coinsurance.	• The Part B Deductible.
Tufts Medicare Preferred Supplement Core Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the allowed charge for manual manipulation of the spine. This benefit must be furnished: (1) by a chiropractor and (2) to correct a subluxation of the spine.		

**Benefits for covered services are provided based on the allowed charge. You may have to pay any amount over the allowed charge.*

Diabetic Services and Supplies		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
When covered by Medicare: Medicare benefits in full, except: • The Part B Deductible; • The Part B Coinsurance.	When covered by Medicare: • The Part B Coinsurance.	When covered by Medicare: • The Part B Deductible.
When not covered by Medicare: • Nothing.	When not covered by Medicare: • Nothing.	When not covered by Medicare: • All charges.
Tufts Medicare Preferred Supplement Core Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the allowed charge for certain Medicare-approved Part B diabetes supplies. These supplies include such items as: blood sugar (glucose) test strips, blood sugar monitors (glucometers), lancet devices and lancets, glucose control solutions for checking test strips and monitoring accuracy, therapeutic shoes or inserts for Members with severe diabetic foot disease. Notes: • Part B diabetes supplies are covered under the durable medical equipment (DME) benefit. • The following diabetes-related drugs and supplies are **not covered** by either Medicare or this Plan: insulin (unless used with an insulin pump), insulin pens, syringes; needles, alcohol swabs, or gauze. Insulin and certain medical supplies used to inject insulin, such as syringes, gauze, and alcohol swabs are covered under Medicare Part D. You will need to enroll in Medicare Part D to receive coverage for these drugs and supplies.		

Diagnostic Tests, X-rays and Clinical Laboratory Services		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
Medicare benefits in full, except: • The Part B Deductible; The Part B Coinsurance.	• The Part B Coinsurance.	• The Part B Deductible.
Tufts Medicare Preferred Supplement Core Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the allowed charge for Medicare-approved outpatient diagnostic tests, X-rays, and clinical laboratory services.		

**Benefits for covered services are provided based on the allowed charge. You may have to pay any amount over the allowed charge.*

Dialysis (Kidney) Services and Supplies		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
Medicare benefits in full, except: • The Part B Deductible; • The Part B Coinsurance.	• The Part B Coinsurance.	• The Part B Deductible.
Tufts Medicare Preferred Supplement Core Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the allowed charge for Medicare-approved outpatient maintenance dialysis treatment services and self-dialysis training, as well as certain home dialysis treatment services.		

Durable Medical Equipment and Prosthetic Devices		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
Medicare benefits in full, except: • The Part B Deductible; • The Part B Coinsurance.	• The Part B Coinsurance.	• The Part B Deductible.
Tufts Medicare Preferred Supplement Core Covered Services		
Once Medicare provides coverage, (including some types of breast prostheses after mastectomy) the Plan provides coverage up to the allowed charge for Medicare-approved DME and prosthetic devices.		

Emergency Room Care		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
Medicare benefits in full, except: • The Part B Deductible; • The Part B Coinsurance.	• The Part B Coinsurance.	• The Part B Deductible.
Tufts Medicare Preferred Supplement Core Covered Services		
Once Medicare approves the coverage, the Plan provides coverage up to the allowed charge for Medicare-approved emergency room care. **Note:** At the onset of a medical condition that you judge to be an emergency, go to the nearest emergency medical facility. For more information, see Guidelines for Receiving Covered Emergency Care in Chapter 1.		

**Benefits for covered services are provided based on the allowed charge. You may have to pay any amount over the allowed charge.*

Enteral Formulas, Low-Protein Food Products		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
When covered by Medicare: Medicare benefits in full, except: • The Part B Deductible; • The Part B Coinsurance.	When covered by Medicare: • The Part B Coinsurance.	When covered by Medicare: • The Part B Deductible.
When not covered by Medicare: • Nothing.	When not covered by Medicare benefits in full: • For certain enteral formulas. • For low-protein food products up to $5,000 per calendar year.	When not covered by Medicare: • Nothing for certain enteral formulas. • All charges for low-protein food products after the Plan pays $5,000 in a calendar year.
Tufts Medicare Preferred Supplement Core Covered Services		
The Plan provides coverage up to the allowed charge for the following formulas and food products: • Enteral formulas for home use for treatment of malabsorption caused by: Crohn's disease, ulcerative colitis; gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids. The Plan covers these formulas in full up to their allowed charge. • Food products modified to be low protein when medically necessary to treat inherited diseases of amino acids and organic acids. Note that Medicare does not cover these food products. The Plan covers these products up to a maximum of $5,000 per calendar year. You are responsible for paying any additional charges for these products in a calendar year.		

**Benefits for covered services are provided based on the allowed charge. You may have to pay any amount over the allowed charge.*

Foreign Travel		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
• Nothing for services received outside the United States.	• All expenses Medicare would have paid for if services had been received in the United States, plus the Medicare Part A and B deductible and coinsurance.	• Nothing.
Tufts Medicare Preferred Supplement Core Covered Services		

Medicare generally does not cover services that you receive while traveling outside of the United States and its territories. For more information on this topic, please refer to your Medicare Handbook.
• For services that Medicare would have covered if you had received them in the United States, the Plan provides benefits for both:
  • The covered services listed in this Policy.
  • The benefits that Medicare normally provides that are listed in this Policy.
Note: The Plan will not pay for any services if you establish residency outside of the United States or its territories.		

Home Health Care		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
For Medicare covered home visits, Medicare benefits in full, except: • The Part B Deductible; • The Part B Coinsurance.	• The Part B Deductible; • The Part B Coinsurance.	• Nothing.
Tufts Medicare Preferred Supplement Core Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the allowed charge for Medicare-approved home health care services. **Note:** The Plan also provides coverage up to the allowed charge for DME required as part of Medicare-approved home health care services. This coverage is provided once Medicare provides benefits for this equipment.		

**Benefits for covered services are provided based on the allowed charge. You may have to pay any amount over the allowed charge.*

Hospice Care		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
When covered by Medicare: • Medicare benefits in full for most services.	When Medicare does not provide benefits in full: • The difference between the amount Medicare pays and the allowed charge.	When covered by Medicare: • Nothing.
When not covered by Medicare: • Nothing.	When not covered by Medicare: • Covered services in full.	When not covered by Medicare: • Nothing.
Tufts Medicare Preferred Supplement Core Covered Services		
If Medicare does not provide either full benefits or any benefits for hospice care services, the Plan provides coverage up to the allowed charge for the following hospice care services required for a terminally-ill person (a person with a life expectancy of six months or less) under Massachusetts law: • The following services when they are either provided or arranged for by a hospice care provider: physician services, nursing care provided by or supervised by a registered professional nurse; social work services, volunteer services, home health aide services, counseling services, DME, and drugs; • Respite care (care for the terminally ill person to provide relief to the family or other person providing primary care to that person). • Bereavement counseling services for the Member's family.		

**Benefits for covered services are provided based on the allowed charge. You may have to pay any amount over the allowed charge.*

Hospital Medical and Surgical Care – Inpatient (Including Care for Biologically-Based Mental Disorders)		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
Medicare benefits in full in a general hospital facility per benefit period, except: • The Part A Deductible for days 1-60; • The Part A Coinsurance for days 61-90; • The Part A Coinsurance for 60 lifetime reserve days.	Per benefit period: • The Part A Coinsurance for days 61-90; • The Part A Coinsurance for 60 lifetime reserve days; • Covered services in full up to an additional 365 days per lifetime after Medicare benefits are used up.	Per benefit period: • The Part A Deductible for days 1-60; • Nothing for days 61-90; • Nothing for up to 60 lifetime reserve days; • Nothing for covered services up to an additional 365 days per lifetime after Medicare benefits are used up; • Then, all charges.
Medicare benefits in full for physician and other professional provider services, except: • The Part B Deductible; • The Part B Coinsurance.	• The Part B Coinsurance.	• The Part B Deductible.
Tufts Medicare Preferred Supplement Core Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the allowed charge for all Medicare-approved inpatient days during a benefit period. This Tufts Health Plan Medicare Preferred Medicare Supplement coverage is provided for: • The 1st 60 days of a benefit period; • The 61st through 90th day of a benefit period; and • The 60 lifetime Medicare reserve days. Once you have used up all of your Medicare reserve days, the Plan provides coverage up to the allowed charge for an additional 365 lifetime inpatient days. These additional days are only covered for semi-private room and board charges.		

**Benefits for covered services are provided based on the allowed charge. You may have to pay any amount over the allowed charge.*

Hospital Medical and Surgical Care - Outpatient (including Ambulatory Surgical Centers)		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
Medicare benefits in full in a general hospital facility or ambulatory surgical center, except: • The Part B Deductible; • The Part B Coinsurance.	•The Part B Coinsurance.	• The Part B Deductible.
Medicare benefits in full for physician and other professional provider services, except: • The Part B Deductible; • The Part B Coinsurance.	•The Part B Coinsurance.	• The Part B Deductible.
Tufts Medicare Preferred Supplement Core Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the allowed charge for Medicare-approved outpatient hospital and medical care including: physician services, outpatient medical services and supplies, physical and speech therapy, diagnostic tests, and DME. Once Medicare provides coverage, the Plan provides coverage up to the allowed charge for outpatient surgical care provided in a Medicare-approved facility (for example, a general hospital or an ambulatory surgical center).		

**Benefits for covered services are provided based on the allowed charge. You may have to pay any amount over the allowed charge.*

Human Organ Transplants		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
Medicare benefits on an inpatient basis as described under Hospital Medical and Surgical Care – Inpatient.	As described under Hospital Medical and Surgical Care – Inpatient.	As described under Hospital Medical and Surgical Care – Inpatient.
Medicare benefits on an outpatient basis as described under Hospital Medical and Surgical Care – Outpatient.	As described under Hospital Medical and Surgical Care – Outpatient.	As described under Hospital Medical and Surgical Care – Outpatient.
Tufts Medicare Preferred Supplement Core Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the allowed charge for Medicare-approved human organ transplants. • Medicare Part A provides coverage under certain conditions and only at Medicare-approved facilities for transplants of: the heart; lung, kidney, pancreas, intestine; and liver. • Medicare Part B provides coverage for cornea and bone marrow transplants. For more information about this coverage under Medicare Part A and Part B, see your Medicare Handbook or contact Medicare.		

Medical Care Outpatient Visits by a Physician or Covered Practitioner (Non-physician)		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
Medicare benefits in full, except: • The Part B Deductible; • The Part B Coinsurance.	• The Part B Coinsurance.	• The Part B Deductible.
Tufts Medicare Preferred Supplement Core Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the allowed charge for Medicare-approved medical care used to diagnose or treat an illness or injury such as: • Office, home, or clinic visits; • Medical nutrition therapy services; • Hormone replacement therapy for peri- and post-menopausal women; • Follow-up medical care following an accidental injury or an emergency.		

**Benefits for covered services are provided based on the allowed charge. You may have to pay any amount over the allowed charge.*

Mental Health and Substance Abuse Services		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
Treatment for Biologically-based Mental Disorders (includes substance abuse disorders):		
Medicare benefits in full for inpatient stay in a general or mental hospital, except: Per benefit period: • The Part A Deductible for days 1-60; • The Part A Coinsurance for days 61-90; • The Part A Coinsurance for 60 lifetime reserve days. Note: Medicare benefits in a mental hospital are limited to 190 days per lifetime.	Inpatient stay in a general or mental hospital Per benefit period: • The Part A Coinsurance for days 61-90; • The Part A Coinsurance 60 lifetime reserve days; • Covered services in full up to an additional 365 days per lifetime after Medicare benefits are used up.	Inpatient stay in a general or mental hospital Per benefit period: • The Part A Deductible for days 1-60; • Nothing for days 61-90; • Nothing for up to 60 lifetime reserve days; • Nothing for covered services up to an additional 365 days per lifetime after Medicare days are used up; • Then, all charges.
Medicare benefits in full for inpatient physician and other covered professional mental health provider services for as many days as medically necessary, except: • The Part B Deductible; • The Part B Coinsurance.	Inpatient physician and other covered professional mental health provider services for as many days as medically necessary • The Part B Coinsurance; • Covered services in full when benefits provided only by the Plan.	Inpatient physician and other covered professional mental health provider services • The Part B Deductible.
Medicare benefits in full for outpatient treatment, except: • The Part B Deductible; • The Part B Coinsurance.	Outpatient treatment for as many days as medically necessary • The Part B Coinsurance; • Covered in full for covered benefits provided only by the Plan.	Outpatient treatment for as many days as medically necessary • The Part B Deductible.

**Benefits for covered services are provided based on the allowed charge. You may have to pay any amount over the allowed charge.*

Mental Health and Substance Abuse Services continued		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
Treatment for other Mental Disorders not included in previous section:		
Medicare benefits in full for inpatient stay in a general hospital, except: Per Benefit Period: • The Part A Deductible for days 1-60; • The Part A Coinsurance for days 61-90; • The Part A Coinsurance for 60 lifetime reserve days.	Inpatient stay in a general hospital Per benefit period: • The Part A Coinsurance for days 61-90; • The Part A Coinsurance 60 lifetime reserve days; • Covered services in full up to an additional 365 days per lifetime** after Medicare benefits are used up.	Inpatient stay in a general hospital Per benefit period: • The Part A Deductible for days 1-60; • Nothing for days 61-90; • Nothing for up to 60 lifetime reserve days; • Nothing for covered services up to an additional 365 days per lifetime** after Medicare days are used up; • Then, all charges.
Medicare benefits in full for inpatient stay in a mental hospital, except: Per benefit period: • The Part A Deductible for days 1-60; • The Part A Coinsurance for days 61-90; • The Part A Coinsurance for 60 lifetime reserve days. **Note:** Medicare benefits in a mental hospital are limited to 190 days per lifetime.	Inpatient stay in a mental hospital Per benefit period: • The Part A Coinsurance for days 61-90; • The Part A Coinsurance 60 lifetime reserve days; • Covered Services up to 120 additional days per Benefit Period (at least 60 days per calendar year) in a mental Hospital, less any days in a mental Hospital already covered by Medicare or the Plan in that Benefit Period or calendar year.	Inpatient stay in a mental hospital Per benefit period: • The Part A Deductible for days 1-60; • Nothing for days 61-90; • Nothing for up to 60 lifetime reserve days; • Covered Services up to 120 days per Benefit Period (at least 60 days per calendar year) in a mental Hospital; • Then, all charges.

**Benefits for covered services are provided based on the allowed Charge. You may have to pay any amount over the allowed charge.*

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

Mental Health and Substance Abuse Services continued		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
Treatment for non-Biologically-based Mental Disorders not included in previous section continued:		
Medicare benefits in full for inpatient physician and other covered professional mental health provider services for as many days as medically necessary, except: • The Part B Deductible; • The Part B Coinsurance.	Inpatient physician and other covered professional mental health provider services covered by Medicare and the Plan for as many days as medically necessary in a general hospital: • The Part B Coinsurance; • Covered Services in full for as many days as Medically Necessary in a general Hospital and up to 120 additional days per benefit period (at least 60 days per calendar year) in a mental Hospital when covered only by the Plan.	Inpatient physician and other covered professional mental health provider services • The Part B Deductible.
Medicare benefits in full for medically necessary outpatient treatment, except: • The Part B Deductible; • The Part B Coinsurance.	Outpatient treatment for as many visits as medically necessary • The Part B Coinsurance; • Covered services in full when covered only by the Plan.	Outpatient treatment for as many visits as medically necessary: • The Part B Deductible, then nothing for Medicare and Plan benefits for as many visits as medically necessary; • Nothing for visits when covered only by the Plan.

**Benefits for covered services are provided based on the allowed charge. You may have to pay any amount over the allowed charge.*

Mental Health and Substance Abuse Services continued
Tufts Medicare Preferred Supplement Core Covered Services
The Plan provides coverage for: • Services to diagnose or treat biologically-based mental disorders. • Treatment of rape-related mental or emotional disorders. • Services to diagnose or treat other mental disorders.
Biologically-based Mental Disorders (including substance abuse and alcoholism) and Rape-related Mental or Emotional Disorders:
The Plan provides coverage up to the allowed charge for biologically-based mental disorders and rape-related mental or emotional disorders as follows: • Once Medicare provides coverage, the Plan provides coverage up to the allowed charge for all Medicare-approved inpatient days during a benefit period. This Tufts Health Plan Medicare Preferred Medicare Supplement coverage is provided for: • The 1st 60 days of a benefit period; • The 61st through 90th day of a benefit period; and • The 60 lifetime Medicare reserve days. Once you have used up all of your Medicare reserve days, the Plan provides coverage up to the allowed charge for an additional 365 lifetime inpatient days. These additional days are only covered for semi-private room and board charges. Note: These limits also apply to all other inpatient stays. For more information, see the benefit description for Hospital Medical and Surgical Care - Inpatient earlier in this chapter. • Once Medicare provides coverage, the Plan provides coverage up to the allowed charge for inpatient services provided by a physician specializing in psychiatry or a psychologist. If Medicare does not provide coverage, the Plan provides coverage up to the allowed charge for inpatient services provided by a physician specializing in psychiatry, a psychologist, or a clinical specialist in psychiatric and mental health nursing. The Plan provides this coverage for as many days as are medically necessary. • Once Medicare provides coverage, the Plan provides coverage up to the allowed charge for outpatient services provided by a mental health care provider. If Medicare does not provide coverage, the Plan provides coverage up to the Allowed Charge for Inpatient services provided by a physician specializing in psychiatry, a psychologist, a licensed independent clinical social worker, a clinical specialist in psychiatric and mental health nursing, or a licensed mental health counselor. The Plan provides this coverage for as many visits as are medically necessary. **Note:** Coverage of other, non-mental health treatment of autism and autism spectrum disorders is described under Autism Spectrum Disorders – Diagnosis and Treatment earlier in this chapter.

**Benefits for covered services are provided based on the allowed charge. You may have to pay any amount over the allowed charge.*

Mental Health and Substance Abuse Services continued
Tufts Medicare Preferred Supplement Core Covered Services
All other Mental Disorders
The Plan provides coverage up to the allowed charge for all other mental disorders: • Once Medicare provides coverage, the Plan provides coverage up to the allowed charge for all Medicare-approved inpatient days during a benefit period. The Plan coverage is provided for: • The 1st 60 days of a benefit period; • The 61st through 90th day of a benefit period; and • The 60 lifetime reserve days. Once you have used up all of your reserve days, the Plan provides coverage up to the allowed charge for an additional 365 lifetime inpatient days. These additional days are only covered for semi-private room and board charges. Note: These limits also apply to all other inpatient stays. For more information, see the benefit description for Hospital Medical and Surgical Care - Inpatient earlier in this chapter. The Plan provides coverage up to the allowable charge under this benefit for: • Up to 120 days per Benefit Period (but covered for at least 60 days per calendar year). This may occur when your Inpatient days are covered by Medicare or the Plan during a Benefit Period (or in the same calendar year). This may occur when your inpatient days are covered by Medicare or the Plan during a benefit period (or in the same calendar year). • Up to a total of 365 lifetime inpatient days. Once Medicare provides coverage, the Plan provides coverage up to the allowed charge for outpatient services provided by a physician specializing in psychiatry or a psychologist. If Medicare does not provide coverage, the Plan provides coverage up to the allowed charge for inpatient services provided by a physician specializing in psychiatry, a psychologist, or a clinical specialist in psychiatric and mental health nursing.
Intermediate Mental Health Care Services
In certain instances, you may need covered services that are more intensive than outpatient services (but not requiring a 24-hour inpatient hospital admission). Both Medicare and the Plan cover these intermediate mental health care services. As a result, Medicare will decide whether this care is medically necessary for you. These services include, but are not limited to: intensive outpatient programs; acute residential; and partial Hospital programs.

**Benefits for covered services are provided based on the allowed charge. You may have to pay any amount over the allowed charge.*

Oxygen and Equipment		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
Medicare benefits in full, except: • The Part B Deductible; • The Part B Coinsurance.	• The Part B Coinsurance.	• The Part B Deductible.
Tufts Medicare Preferred Supplement Core Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the allowed charge for • The rental of oxygen equipment; and • Oxygen contents and supplies for the delivery of oxygen.		

Podiatry		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
Medicare benefits in full, except: • The Part B Deductible; • The Part B Coinsurance.	• The Part B Coinsurance.	• The Part B Deductible.
Tufts Medicare Preferred Supplement Core Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the allowed charge for: • Treatment of injuries and diseases of the feet (such as hammer toe and spurs). • Routine foot care** for Members with certain medical conditions affecting the lower limbs. **For information about foot care related to diabetes, see Diabetes Services and Supplies in this Benefit Schedule.		

**Benefits for covered services are provided based on the allowed charge. You may have to pay any amount over the allowed charge.*

Prescription Drugs – Limited Outpatient Drug Coverage under Medicare Part B		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
When covered by Medicare, Medicare benefits in full, except: • The Part B Deductible; • The Part B Coinsurance.	When covered by Medicare, • The Part B Coinsurance.	When covered by Medicare, • The Part B Deductible.
Tufts Medicare Preferred Supplement Core Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the allowed charge for a limited number of outpatient prescription drugs covered under Medicare Part B. Some examples include certain drugs in the following categories: • Osteoporosis drugs; • Injectable drugs given by a licensed medical practitioner; • Oral cancer drugs; and • Oral anti-nausea drugs. For more information about this Part B benefit, see your Medicare Handbook or contact Medicare. Note: This Plan does not pay for most prescription drugs. You pay the full cost for most prescription drugs. In order to receive the full prescription drug benefits available through Medicare, you need to enroll in Medicare Part D coverage.		

Preventive Care – Annual Prostate Cancer Screenings		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
Medicare benefits as follows for annual prostate cancer screenings: • Full benefit for annual Prostate-Specific Antigen (PSA) test. • Annual digital rectal exam covered, subject to • The Part B Deductible; • The Part B Coinsurance	• Nothing. • The Part B Coinsurance.	• Nothing. • The Part B Deductible.
Tufts Medicare Preferred Supplement Core Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the allowed charge for the following routine prostate cancer screenings: • Digital rectal exam: one exam per year for Members age 50 or older. • PSA blood test: one test per year for Members age 50 or older. **Note:** The Plan may also provide coverage up to the allowed charge for additional prostate cancer screenings determined by Medicare to be medically necessary.		

**Benefits for covered services are provided based on the allowed charge. You may have to pay any amount over the allowed charge.*

Preventive Care – Annual Screening Mammograms		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
Medicare benefits in full for annual screening mammogram.	• Nothing.	• Nothing.
Tufts Medicare Preferred Supplement Core Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the allowed charge for mammograms as follows: • One baseline mammogram for a Member between ages 35 and 39. • One routine mammogram each calendar year for a Member age 40 or older. Note: The Plan also provides coverage up to the allowed charge for medically necessary diagnostic mammograms. For more information, see Laboratory Tests, X-rays, and Other Diagnostic Tests earlier in this chapter.		

Preventive Care – Annual Wellness Exam		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
Medicare benefits in full for an annual wellness exam. Note: This benefit applies in years following the initial "Welcome to Medicare" exam.	• Nothing.	• Nothing.
Tufts Medicare Preferred Supplement Core Covered Services		
Medicare provides coverage for an annual wellness exam. This benefit applies in years following the initial one-time "Welcome to Medicare" exam to develop or update a personalized plan to prevent disease or disability based on your current health risk factors.		

Preventive Care – Bone Mass Density Testing		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
Medicare benefits in full for screening bone mass density testing.	• Nothing.	• Nothing.

**Benefits for covered services are provided based on the allowed charge. You may have to pay any amount over the allowed charge.*

Preventive Care – Bone Mass Density Testing continued
Tufts Medicare Preferred Supplement Core Covered Services
Once Medicare provides coverage, the Plan provides coverage up to the allowed charge for Medicare-approved bone mass density testing. This testing is provided to: identify bone mass; determine bone quality; or detect bone loss. For more information, see your Medicare Handbook or contact Medicare.

Preventive Care – Cardiovascular Screening		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
Medicare benefits in full for routine cardiovascular screening.	• Nothing.	• Nothing.
Tufts Medicare Preferred Supplement Core Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the allowed charge for screenings once every five years to test a Member's cholesterol, lipid, and triglyceride levels.		

Preventive Care – Colorectal Cancer Screenings		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***

Medicare benefits as follows for routine colorectal cancer screenings:
• Full benefits for Guaiac-based fecal occult blood test (gFOBT) or Fecal immunochemical test (FIT), flexible sigmoidoscopy, colonoscopy, and DNA based colorectal screening.
• Barium enema covered, subject to:
  • The Part B Deductible;
  • The Part B Coinsurance.
	• Nothing.
	
	• The Part B Coinsurance.
		• Nothing.
		
		• The Part B Deductible.

**Benefits for covered services are provided based on the allowed charge. You may have to pay any amount over the allowed charge.*

Preventive Care – Colorectal Cancer Screenings continued
Tufts Medicare Preferred Supplement Core Covered Services
Once Medicare provides coverage, the Plan provides coverage up to the allowed charge for the following routine colorectal cancer services: • Guaiac-based fecal occult blood test (gFOBT) or Fecal immunochemical test (FIT): one test per year for Members age 50 or older. • Flexible Sigmoidoscopy: one test every four years for Members age 50 or older. • Colonoscopy: one test every two years for Members determined by Medicare to be at high risk for developing colorectal cancer. • Colonoscopy: one test every ten years for Member determined by Medicare not to be at high risk of colorectal cancer, but not within four years of a screening sigmoidoscopy. • Barium Enema: one test every four years for Members age 50 or older • DNA based colorectal screening every three years

Preventive Care – Diabetes Self-Management Training		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
Medicare benefits in full for diabetes self-management training, except: • The Part B Deductible; • The Part B Coinsurance.	• The Part B Coinsurance.	• The Part B Deductible.
Tufts Medicare Preferred Supplement Core Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the allowed charge for outpatient self-management training and educational services, including medical nutrition therapy, used to diagnose or treat: insulin-dependent diabetes; non-insulin dependent diabetes; or gestational diabetes.		

**Benefits for covered services are provided based on the allowed charge. You may have to pay any amount over the allowed charge.*

Preventive Care – Family Planning		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
For family planning: • Nothing.	• Benefits in full as required by state mandate.	• Nothing.
Tufts Medicare Preferred Supplement Core Covered Services		
The Plan provides coverage up to the allowed charge for the following family planning services: • Consultations, examinations, procedures and medical services, which are related to the use of all contraceptive methods that have been approved by the United State Food and Drug Administration (USFDA). • The injection of birth control drugs, including a prescription drug obtained from the Provider during an office visit. • Genetic counseling. • Insertion of implantable contraceptives, including levonorgestrel implants. Coverage includes the implant system as well. Intrauterine devices (IUDs), diaphragms, and any other USFDA-approved contraceptive methods, when these contraceptives are obtained from the Provider during an office visit.		

Preventive Care – Glaucoma Testing		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
Medicare benefits in full for glaucoma testing, except: • The Part B Deductible; • The Part B Coinsurance.	• The Part B Coinsurance.	• The Part B Deductible.
Tufts Medicare Preferred Supplement Core Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the allowed charge for one glaucoma test every 12 months. This coverage is for Members that Medicare decides to be at high risk for glaucoma.		

**Benefits for covered services are provided based on the allowed charge. You may have to pay any amount over the allowed charge.*

Preventive Care – Medical Nutrition Therapy		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
Medicare benefits in full for Medical Nutrition Therapy	• Nothing.	• Nothing.
Tufts Medicare Preferred Supplement Core Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the allowed charge for Medicare-approved medical nutritional therapy services for Members with diabetes or kidney disease.		

Preventive Care – Medicare Diabetes Prevention Program (MDPP)		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
Medicare benefits in full for the Medicare Diabetes Prevention Program	• Nothing.	• Nothing.
Tufts Medicare Preferred Supplement Core Covered Services		
MDPP is a structured health behavioral change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.		

Preventive Care – Pelvic and Clinical Breast Exams and Routine Cytology Exam (Pap Smear)		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
Medicare benefits in full for pelvic, Pap Smear, and clinical breast exams	• Nothing.	• Nothing.
Medicare benefits in full for a Pap smear test every two years.	In full for an annual routine Pap smear test each calendar year (covered in years when Medicare benefits do not cover this test).	• Nothing.
Tufts Medicare Preferred Supplement Core Covered Services		
Medicare-covered exams and tests: Once Medicare provides coverage, the Plan provides coverage up to the allowed charge for one gynecological exam (including a routine Pap smear) every two years. This coverage is provided every year for a Member that Medicare determines to be at high risk for developing cervical or vaginal cancer. Non-Medicare-covered exams and tests: If Medicare does not provide coverage for a routine cytological exam (Pap smear) per calendar year, the Plan provides full coverage up to the Allowed Charge for that exam.		

**Benefits for covered services are provided based on the allowed charge. You may have to pay any amount over the allowed charge.*

Preventive Care – Screening for Lung Cancer with Low Dose Computed Tomography (LDCT)		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
Medicare benefits in full for screening for lung cancer with low dose computed tomography (LDCT)	• Nothing.	• Nothing.
Tufts Medicare Preferred Supplement Core Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for screening for lung cancer with low dose computed tomography (LDCT) Note: For qualified Members, a LDCT is covered every 12 months. **Eligible Members are:** people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years (an average of one pack a day for 30 years) or who currently smoke or have quit smoking within the last 15 years, who receive a written 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 enrollee Member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits. Note: There is no Coinsurance, Copayment, or Deductible for the Medicare covered counseling and shared decision making visit or for the LDCT.		

**Benefits for covered services are provided based on the allowed charge. You may have to pay any amount over the allowed charge.*

Preventive Care – Smoking and Tobacco Use Cessation Counseling		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
Medicare benefits in full for a Medicare approved smoking cessation program for members who have not been diagnosed with an illness caused or complicated by tobacco use.	• Nothing.	• Nothing.
For members diagnosed with an illness caused or complicated by tobacco use: Medicare benefits in full except for: • The Part B Deductible; • The Part B Coinsurance.	• The Part B Coinsurance.	• The Part B Deductible.
Tufts Medicare Preferred Supplement Core Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the allowed charge for a Medicare-approved smoking cessation program. This coverage includes up to 8 face-to-face visits in a 12-month period.		

Preventive Care – "Welcome to Medicare" Visit		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
Medicare benefits in full for a one time visit within 12 months after Part B coverage begins.	• Nothing.	• Nothing.
Tufts Medicare Preferred Supplement Core Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the allowed charge for a one-time "Welcome to Medicare" visit. **Note:** Medicare covers this visit when a Member receives it within 12 months after enrolling in Medicare Part B.		

**Benefits for covered services are provided based on the allowed charge. You may have to pay any amount over the allowed charge.*

Radiation and X-ray Therapy		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
Medicare benefits in full, except: • The Part B Deductible; • The Part B Coinsurance.	• The Part B Coinsurance.	• The Part B Deductible.
Tufts Medicare Preferred Supplement Core Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the allowed charge for radiation and X-ray therapy.		

Second Opinions		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
Medicare benefits in full, except: • The Part B Deductible; • The Part B Coinsurance.	• The Part B Coinsurance.	• The Part B Deductible.
Tufts Medicare Preferred Supplement Core Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the allowed charge for: (1) an outpatient second opinion regarding your medical care; or (2) a second surgical opinion. Coverage may also be provided for a third opinion, when the second opinion is different from the initial opinion.		

Short-Term Rehabilitation Therapy (Physical, Occupational & Speech-Language)		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
Medicare benefits in full, except: • The Part B Deductible; • The Part B Coinsurance.	• The Part B Coinsurance.	• The Part B Deductible.
Tufts Medicare Preferred Supplement Core Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the allowed charge for outpatient short-term rehabilitation therapy. This coverage includes: physical therapy, occupational therapy, and speech therapy. Also, the Plan provides coverage for medically necessary services required to diagnose and treat speech, hearing, and language disorders.		

**Benefits for covered services are provided based on the allowed charge. You may have to pay any amount over the allowed charge.*

Skilled Nursing Facility Services		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
Medicare benefits per benefit period: • In full for days 1-20; • In full for days 21-100, except for the Part A Coinsurance; • Nothing for day 101 and beyond.	Per benefit period: • Nothing. • Nothing. • Nothing.	Per benefit period: • Nothing. • The Part A Coinsurance. • All costs.
Tufts Medicare Preferred Supplement Core Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the allowed charge for skilled nursing facility services. This coverage is provided through the 100th day in a benefit period. **Note:** Medicare and the Plan both provide coverage for skilled nursing facility services, when a Member's inpatient stay in such a facility meets Medicare's rules. These rules include Medicare's requirement that the Member: (1) be an inpatient in a hospital for at least three days; and then (2) transfer to the skilled nursing facility within 30 days after leaving that hospital.		

Surgery as an Outpatient		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
Medicare benefits in full, except: • The Part B Deductible; • The Part B Coinsurance.	• The Part B Coinsurance.	• The Part B Deductible.
Tufts Medicare Preferred Supplement Core Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the allowed charge for Medicare-approved outpatient surgery.		

**Benefits for covered services are provided based on the allowed charge. You may have to pay any amount over the allowed charge.*

Women's Health and Cancer Rights Act Coverage		
Medicare Pays	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
Medicare benefits on an inpatient basis as described under Hospital Medical and Surgical Care – Inpatient. Medicare benefits on an outpatient basis as described under Hospital Medical and Surgical Care – Outpatient.	As described under Hospital Medical and Surgical Care – Inpatient. As described under Hospital Medical and Surgical Care – Outpatient.	As described under Hospital Medical and Surgical Care – Inpatient. As described under Hospital Medical and Surgical Care – Outpatient.
Tufts Medicare Preferred Supplement Core Covered Services		
The Plan provides coverage up to the allowed charge for breast reconstruction in connection with a mastectomy. This includes the following services: • Reconstruction of the breast affected by the mastectomy; • Surgery and reconstruction of the other breast to produce a symmetrical appearance, and; • Prostheses and treatment of physical complications of all stages of mastectomy (including lymphedema).		

Additional Covered Services Provided by the Plan (for benefits not covered under Parts A and B of Medicare)		
Medicare Pays nothing for the following Covered Services provided by the Plan:	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
• Cleft lip or cleft palate treatment and services for children, in accordance with Massachusetts law. See Covered Services below.	All charges.	Nothing.
• Fitness and Nutritional Counseling Benefit.	All combined charges up to a maximum benefit of $150 per calendar year.	All costs, after the maximum benefit of up to $150 per calendar year is reached.
• Hearing aids for children age 21 and under in accordance with Massachusetts law. See Covered Services below.	All charges for one (1) hearing aid per hearing impaired ear up to $2,000 every 36 months. All charges for covered hearing aid evaluations, fittings and adjustments, and supplies, including ear molds.	All costs after Plan pays for one (1) hearing aid per hearing impaired ear up to $2,000 every 36 months Nothing for covered hearing aid evaluations, fittings and adjustments, and supplies, including ear molds.

**Benefits for covered services are provided based on the allowed charge. You may have to pay any amount over the allowed charge.*

Additional Covered Services Provided by the Plan (for benefits not covered under Parts A and B of Medicare) continued		
Medicare Pays nothing for the following Covered Services provided by the Plan:	**Tufts Medicare Preferred Supplement Core Pays**	**You Pay***
• Outpatient substance services for medication assisted treatment, including methadone maintenance.	All charges.	Nothing.
• Medically Necessary diagnosis and antibiotic treatment of chronic Lyme disease. • Long-term antibiotic treatment of chronic Lyme disease. Treatments for Lyme disease otherwise eligible for coverage under this benefit will not be denied solely because such treatment may be characterized as unproven, Experimental or Investigative.	All charges.	Nothing.
Tufts Medicare Preferred Supplement Core Covered Services		
Cleft lip or cleft palate treatment and services for children: In accordance with Massachusetts law, the following services are covered for children under the age of 18 when services are prescribed by the treating physician or surgeon, and that Provider certifies that the services are medically necessary and required because of the cleft lip or cleft palate: • Medical and facial surgery: This includes surgical management and follow-up care by plastic surgeons; • Oral surgery: This includes surgical management and follow-up care by oral surgeons; • Dental surgery or orthodontic treatment and management; • Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management therapy; • Speech therapy and audiology services; • Nutrition services. **Fitness and Nutritional Counseling benefit:** Covers up to a total of $150 per calendar year towards membership fees and/or exercise classes for a Member enrolled in a qualified health club or fitness facility and/or covered nutritional counseling sessions with a licensed nutritional counselor or registered dietician (combined charges.) Important notes about this benefit: • A qualified health club or fitness facility provides cardiovascular and strength training exercise equipment on site. Examples include traditional health clubs, YMCAs, YWCAs and community fitness centers.		

**Benefits for covered services are provided based on the allowed charge. You may have to pay any amount over the allowed charge.*

Additional Covered Services Provided by the Plan (for benefits not covered under Parts A and B of Medicare) continued

Tufts Medicare Preferred Supplement Core Covered Services

- This benefit does not cover fees paid to non-qualified health clubs or fitness facilities, including but not limited to, martial arts centers; gymnastics facilities; country clubs; social clubs; facilities providing only yoga, Pilates, aerobics, golf, tennis, swimming or other sports activity
- To obtain up to the $150 Fitness and Nutritional Counseling reimbursement please submit a Fitness/ Nutrition Benefit claim form along with an itemized bill from the qualified facility, licensed nutritional counselor or registered dietician and paid receipts. Call Customer Relations to request a claim form or go to our website thpmp.org. Send the completed claim form, along with the paid receipts, to Customer Relations at the address shown on the claim form.
- Reimbursement requests must be received by Tufts Health Plan Medicare Preferred by no later than March 31st of the following year.
- For more information about this benefit, call Customer Relations.

Hearing aids for Children:
In accordance with Massachusetts law, the following services are covered for children age 21 and under upon written statement from the child's treating physician that the hearing aids are necessary regardless of the cause:

- One (1) hearing aid per hearing impaired ear per prescription change up to $2,000 every 36 months.
- Hearing aid evaluations;
- Fitting and adjustment of hearing aids;
- Supplies, including ear molds.

Discounts and Savings – Preferred Extras

In addition to your covered benefits, as a Member you may take advantage of Preferred Extras - discounts on a variety of health products, services, and treatments. This list of Member discounts is effective January 1, 2019 and may change during the year. Please see our website at thpmp.org. for additional information or call Customer Relations.

Fitness Discounts:

- Fitness Together – Free initial fitness evaluation; 10% discount on personal training packages of 36 sessions or more.

Mind & Body:

- Massage Therapy – 25% discount on usual and customary fee or pay $15 per 15 minutes of massage therapy, whichever is less.
- Acupuncture – 25% discount on usual and customary fee.

Discounts and Savings – Preferred Extras continued

Nutritional Services:

- Jenny Craig*:
  - Free 3 month program (food not included) + $120 in Food Savings (purchase required); or
  - Save 50% off their premium programs (food cost separate)
  - Visit www.jennycraig.com/THPMP OR call 877-536-6970 for a free consultation.

*Please note:

  - Valid for 3-month membership. Discount split over 10 consecutive weeks with weekly full menus average $156 (before discount). Any shipping costs are extra.
  - Food cost subject to change. Valid only at participating centers and JCA. Not valid at jennycraig.com. No cash value. Not valid with any other food offers or discounts.
  - One offer per person. 50% discount on enrollment and/or membership fees for eligible premium programs.
  - Weekly full menus average $156 (before any discount) and any shipping costs are not included.
  - Active program enrollment and eligibility status required, which includes meeting with a consultant weekly and adhering to the full Jenny Craig meal plan.
- Nutritional Counseling – 25% discount on unlimited visits with registered dieticians and licensed nutritionists.
- Dash for Health – Members can sign up for the DASH for Health program for $34.50 for a 6 month subscription (50% off the regular subscription rate).
- The Dinner Daily – This program makes healthy, delicious dinners easy and affordable by providing you with weekly dinner plans customized for your food preferences, dietary needs, and the specials at your local grocery store. Dinner Daily members can save $1,200 or more each year on grocery costs, for less than $1 a week. Eat better dinners, save money and make dinners easy. Members receive 25% on any Dinner Daily subscription – you'll pay as little as 70 cents a week. The first two weeks are free to make it easy to try. To sign up, or for more information, visit https://thedinnerdaily.com/tmp and use TMP25 to receive your discount.

Health Products & Services:

- CVS Caremark ExtraCare® Health Card – Receive 20% off the price of certain CVS/pharmacy Brand, non-prescription, health related-items by using your ExtraCare Health Card offered by CVS Caremark.
- Home Instead Senior Care – $100 one-time credit on non-medical home care services.
- Lasik Surgery – 15% discount on retail price, or 5% off the promotional price, of LASIK and PRK laser vision correction.
- ChooseHealthy.com™ – Free shipping and up to 40% discount on over 2,400 dietary supplements, homeopathic remedies, diet and sports nutrition, personal body care, books, audio videos, DVDs, and more.
- Healing Threads: Members Get 20% off the Original Healing Threads collection of tops and breakaway pants made of soft machine wash and dry polyester micro-fiber.
- Life Cycle Transitions – Tufts Health Plan members can also access a 20% discount for home modifications, house cleaning, hoarding assistance, home improvements, independent living assistance, and more through Life Cycle Transitions.

Discounts and Savings – Preferred Extras continued

- Well Balanced Meals program through Independent Living Systems – Get a 15% discount on home delivered meals through Independent Living Systems. Home delivered meals offer a convenient and affordable way to recover from an illness, a surgical procedure, or to manage a chronic condition
- Be Safer At Home Personal Emergency Response Systems (PERS) – Get a discounted rate on the installation and monthly fees of a Personal Emergency Response System (PERS). A PERS unit allows you to live the independent lifestyle you want by providing a resource that is always there to respond to emergency calls.

Hearing Aid Discount:

- Savings up to 63% below retail.
- 2-year supply of batteries at no charge.
- 1 year in-office servicing at no charge.
- 3-year comprehensive warranty.
- Complete hearing aid evaluation at no charge.
- No interest financing available for 12 months for qualified applicants.
- For details on this discount call Hearing Care Solutions toll-free at 866-344-7756 or call Customer Relations.

Memory Fitness Activities Discount Program:

Tufts Medicare Preferred members can save 17% on a subscription to the BrainHQ application offered by Posit Science. Members access the discount through the following link: http://www.brainhq.com/reg/tmp

What is BrainHQ?

Over time, it gets harder for the brain to process information from our senses quickly and accurately. BrainHQ is designed to reverse these changes. It increases processing speed and sharpens attention so you can capture information no matter how quickly it comes in. Addressing these core issues helps improve memory and other important cognitive skills, so you can lead an even more fulfilling and independent life.

These discounts and savings may change over time without notice to Members.

To check on current Preferred Extras, call Customer Relations at the number listed on your Member ID card, or go to **www.thpmp.org/preferred-extras.**

**Benefits for covered services are provided based on the allowed charge. You may have to pay any amount over the allowed charge.*

LIMITATIONS ON BENEFITS

Dental Care Services:

Dental care is not covered under this Plan. Medicare does not cover routine dental care or most dental procedures such as cleanings, fillings, root canals, tooth extractions and dentures. However, if you need to have emergency or complicated dental procedures, Medicare Part A may pay for your hospital stay even when Medicare does not cover the actual dental care services. For more information, see your Medicare Handbook or contact Medicare.

EXCLUSIONS FROM BENEFITS

List of Exclusions:

Tufts Health Plan Medicare Preferred will not pay for the following services, supplies, or medications:

- A service, supply or medication which is not medically necessary.
- A service, supply or medication which is not a covered service.
- A service, supply or medication that is not essential to treat an injury, illness, or pregnancy, except for preventive care services.
- A service, supply, or medication if there is a less intensive level of service supply, or medication or more cost-effective alternative which can be safely and effectively provided, or if the service, supply, or medication can be safely and effectively provided to you in a less intensive setting.
- A service, supply, or medication that is primarily for your, or another person's, personal comfort or convenience.
- Custodial Care.
- Services related to non-covered services.
- A drug, device, medical treatment or procedure (collectively "treatment") that is Experimental or Investigative.
  - This exclusion does not apply to:
    - Bone marrow transplants for breast cancer; or
    - Patient care services provided pursuant to a qualified clinical trial which meets the requirements of Massachusetts law.
  - If the treatment is Experimental or Investigative, we will not pay for any related treatments which are provided to the Member for the purpose of furnishing the Experimental or Investigative treatment.
- Drugs, medicines, materials or supplies for use outside the hospital or any other facility, except as described earlier in this chapter. Laboratory tests ordered by a Member (online or through the mail), even if performed in a licensed laboratory.
- The following exclusions apply to services provided by the relative of a Member:
  - Services provided by a relative who is not a Provider are not covered.
  - Services provided by an immediate family member (by blood or marriage), even if the relative is a Provider, are not covered.
- If you are a Provider, you cannot provide or authorize services for yourself or a member of your immediate family (by blood or marriage).
- Services, supplies, or medications required by a third party which are not otherwise medically necessary. Examples of a third party are: employer; insurance company; school; or court.
- Services for which you are not legally obligated to pay or services for which no charge would be made if you had no health plan.

- Care for conditions for which benefits are available under workers' compensation or other government programs other than Medicaid.
- Care for conditions that state or local law requires to be treated in a public facility.
- Charges or claims incurred as a result, in whole or in part, of fraud or misrepresentation (e.g., claims for services not actually rendered and/or able to be validated).
- Facility charges or related services if the procedure being performed is not a covered service.
- Cosmetic (meaning to change or improve appearance) surgery, procedures, supplies, medications or appliances, except as provided earlier in this chapter.
  Note: Breast reconstruction is covered when following a medically necessary mastectomy, as described in Women's Health and Cancer Rights Act Coverage earlier in this chapter.
- Human organ transplants, except as described earlier in this chapter.
- Any service, program, supply, or procedure performed in a non-conventional setting including, but not limited to: spas/resorts; educational, vocational or recreational settings; Outward Bound; or wilderness, camp or ranch programs, even if performed or provided by a licensed Provider (including , but not limited to, mental health professionals, nutritionists, nurses or physicians). Examples of services provided in a non-conventional setting that are excluded from coverage include, but are not limited to, psychotherapy, ABA services, and nutritional counseling.
- Multi-purpose general electronic devices, including, but not limited to, laptop computers, desktop computers, personal assistive devices (PDAs), tablets and smartphones. All accessories for multi-purpose general electronic devices, including USB devices and direct connect devices (e.g., speakers, microphones, cables, cameras, batteries). Internet and modem connection/access including, but not limited to Wi-Fi®, Bluetooth®, Ethernet, and all related accessories.
- Hearing aids; except for children age 21 and under as described earlier in this chapter.
- Routine foot care, such as: trimming of corns and calluses; treatment of flat feet or partial dislocations in the feet; orthopedic shoes and related items that are not part of a brace; foot orthotics or fittings; or casting and other services related to foot orthotics or other support devices for the feet, except:
  - This exclusion does not apply to therapeutic/molded shoes and shoe inserts for a Member with severe diabetic foot disease when the need for therapeutic shoes and inserts has been certified by the Member's treating doctor, and the shoes and inserts:
    - Are prescribed by a Provider who is a podiatrist or other qualified doctor; and
    - Are furnished by a Provider who is a podiatrist, orthotist, prosthetist, or pedorthist.
- This exclusion also does not apply to routine foot care for Members diagnosed with diabetes.
- All Non-Conventional Medicine services, provided independently or together with conventional medicines, and all related testing, laboratory testing, services, supplies, procedures and supplements associated with this type of medicine.
- Service or therapy animals and related supplies.

Chapter 4: When Coverage Ends

OVERVIEW

Introduction:
This chapter tells you when coverage ends.

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

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

WHEN A MEMBER IS NO LONGER ELIGIBLE

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

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

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

WHEN A MEMBER IS ENTITLED TO MEDICAID

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

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

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

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

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

MEMBERSHIP TERMINATION FOR MATERIAL MISREPRESENTATION

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

Acts of Material Misrepresentation:
Examples of material misrepresentation include:

- False or misleading information on your application;
- Receiving benefits for which you are not eligible;
- Allowing someone else to use your Member ID; or
- Submission of any false paperwork, forms, or claims information.

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

Payment of Claims:
We will pay for all covered services you received between:

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

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

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

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

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

TERMINATION OF THE INDIVIDUAL CONTRACT

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

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

- Your Individual Contract with us terminates;
- You fail to pay Premiums on time; or
- We stop operating.

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

MEMBER SATISFACTION PROCESS

Tufts Health Plan Medicare Preferred has a multi-level Member Satisfaction Process including:
- Internal Inquiry;
- Member Grievances Process;
- Internal Member Appeals; and
- External Review by the Office of Patient Protection.

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

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

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

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

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

Member Grievance Process:
A grievance is a formal complaint about actions taken by us or a Provider. There are two types of grievances: administrative grievances; and clinical grievances. The two types of grievances are described below.

It is important that you contact us as soon as possible to explain your concern. Grievances may be filed either: verbally; or in writing. If you choose to file a grievance verbally, please call Customer Relations. That person will document your concern and forward it to an Appeals and Grievances Analyst in the Appeals and Grievances

Department. To accurately reflect your concerns, you may want to: put your grievance in writing; and send it to the address provided at the beginning of this section. Your explanation should include:

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

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

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

Administrative Grievance Timeline:

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

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

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

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

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

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

It is important that you contact us as soon as possible to explain your concern. You have 180 days from the date you were notified of the denial of benefit coverage or claim payment to file an internal appeal. Appeals may be filed either verbally or in writing. If you would like to file a verbal appeal, call a Customer Relations Representative who will: document your concern; and forward it to an Appeals and Grievances Analyst. To accurately reflect your concerns, you may want to: put your appeal in writing; and send it to the address provided at the beginning of this section. Your explanation should include:

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

Appeals Timeline:

- If you file your appeal verbally or in writing, we will notify you in writing within forty-eight (48) hours after receiving your written or verbal appeal, that your appeal has been received and; provide you with the name, address, and telephone number of the Appeals and Grievances Analyst coordinating the review of your appeal, and our understanding of your concern.
- If your request for review was first addressed through the internal inquiry process, and does not require the review of medical records, the thirty (30) calendar day review period will begin the day following the end of the three (3) day internal inquiry process or earlier if you notify us that you are not satisfied with the response you received during the internal inquiry process.

- Within 30 calendar days of receipt, we will: review your appeal; make a decision; and send you a decision letter.
- The time limits in this process may be waived or extended beyond the time allowed by law upon mutual verbal or written agreement between: you or your authorized representative; and us.

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

Note: If you need help, the Consumer Assistance Resource Program in Massachusetts can help you file your appeal. Contact:

Health Care for All
30 Winter Street, Suite 1004, Boston, MA 02108
(800) 272-4232 || http://www.hcfama.org/helpline

When Medical Records are Necessary:
If your appeal requires the review of medical records you will receive a form that you will need to sign which authorizes your Providers to release to us medical information relevant to your appeal. You must sign and return the form before we can begin the review process. If you do not sign and return the form to us within thirty (30) calendar days of the date you filed your appeal, we may issue a response to your request without having reviewed the medical records. You will have access to any medical information and records relevant to your appeal, which are in our possession and control.

Who Reviews Appeals?
If the appeal involves a medical necessity determination, an actively practicing health care professional in the same or similar specialty as typically treats the medical condition, performs the procedure, or provides the treatment that is under review, and who did not participate in any of the prior decisions on the case will take part in the review. In addition, a Committee made up of Managers and Clinicians from various Tufts Health Plan Medicare Preferred departments will review your appeal. A Committee within the Appeals and Grievances Department will review appeals involving non-covered services.

Appeal Response Letters:
The letter you receive from us will include identification of the specific information considered for your appeal and an explanation of the basis for the decision. A response letter regarding a final adverse determination (a decision based on medical necessity) will include: the specific information upon which the adverse determination was based; our understanding of your presenting symptoms or condition; diagnosis and treatment interventions, and the specific reasons such medical evidence fails to meet the relevant medical review criteria; alternative treatment options offered, if any; applicable clinical practice guidelines and review criteria; notification of the steps for requesting external review by the Office for Patient Protection; the titles and credentials of the individuals who reviewed the case, and the availability of translation services and consumer assistance programs. Please note that requests for coverage of services that are specifically excluded in your Policy are not eligible for external review.

An appeal not properly acted on by us within the time limits of Massachusetts law and regulations, including any extensions made by mutual written agreement between you or your authorized representative and us, shall be deemed resolved in your favor.

Expedited Appeals:
We recognize that there are circumstances that require a quicker turnaround than the 30 calendar days allotted for the standard Appeals Process. We will expedite an appeal when there is an ongoing service about to terminate or a service to be delivered imminently whereby a delay in treatment would seriously jeopardize your life and health or jeopardize your ability to regain maximum function. Should you feel that your request meets the criteria cited above, you or your attending physician should contact Customer Relations. Under these circumstances, you will be notified of our decision within 2 business days, but no later than seventy-two (72) hours (whichever is less) after the review is initiated. If your treating Provider (the practitioner responsible for the treatment or proposed treatment) certifies that the service being requested is medically necessary; that a denial of coverage for such services would create a substantial risk of serious harm; and such risk of serious harm is so immediate that the provision of such services should not await the outcome of the normal grievance process, you will be notified of our decision within forty-eight (48) hours of the receipt of certification. If you are appealing coverage for Durable Medical Equipment (DME) that we determined was not medically necessary, you will be notified of our decision within less than forty-eight (48) hours of the receipt of certification. If you are an inpatient in a hospital, we will notify you of the decision before you are discharged. If your appeal concerns the termination of ongoing coverage or treatment, the disputed coverage shall remain in effect at our expense through the completion of the Internal Appeals Process. The only services which will continue to be covered are those which: (1) were originally authorized by us; and (2) which were not terminated pursuant to a specific time or episode-related exclusion.

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

If the appeal is denied, the decision will include the specific medical and scientific reasons for denying the coverage, and a description of any alternative treatment, services or supplies that would be covered. If your requests meet the criteria for an expedited review, you may also file an expedited external appeal at the same time.

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

IF YOU ARE NOT SATISFIED WITH THE APPEALS DECISION

"Reconsideration":

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

External Review by the Office of Patient Protection:

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

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

To request an external review by the Office of Patient Protection, you must file your request in writing with the Office of Patient Protection within four (4) months of your receipt of written notice of the denial of your appeal by Tufts Health Plan. The letter from Tufts Health Plan notifying you of the denial will contain the forms and other information that you will need to file an appeal with the Office of Patient Protection. The review panel will make a decision within forty-five (45) calendar days for standard reviews and within seventy-two (72) hours for expedited reviews.

You or your authorized representative may request to have your review processed as an expedited external review. Any request for an expedited external review must contain a certification, in writing, from a physician, that delay in the providing or continuation of health care services, that are the subject of a final adverse determination, would pose a serious and immediate threat to your health. Upon a finding that a serious and immediate threat to your health exists, the Office of Patient Protection will qualify such request as eligible for an expedited external review.

Your cost for an external review by the Office of Patient Protection is $25. This payment should be sent to the Office of Patient Protection, along with your written request for a review. The Office of Patient Protection may waive this fee if it determines that the payment of the fee would result in an extreme financial hardship to you and shall refund the fee to the insured if the adverse determination is reversed in its entirety. We will pay the remainder of the cost for an external review. Upon completion of the external review, the Office of Patient Protection shall bill us the amount established pursuant to contract between the Department and the assigned external review agency minus the $25 fee which is your responsibility. You will not be required to pay more than $75 per plan year, regardless of the number of external review requests submitted.

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

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

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

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

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

Health Policy Commission, Office of Patient Protection.
50 Milk Street, 8th Floor
Boston, MA 02109
Phone: 1-800-436-7757 / Fax: 1-617-624-5046 / Email: HPC-OPP@state.ma.us.
Internet: www.ma.gov/hpc.opp

LIMITATION ON ACTIONS

Limitation on Actions:

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

SUBROGATION

Tufts Health Plan Medicare Preferred's Right of Subrogation:
You may have a legal right to recover some or all of the costs of your health care from someone else (a "Third Party"). "Third Party" means any person or company that is, could be, or is claimed to be responsible for the costs of injuries or illness to you.

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

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

We have the right to recover those costs in your name. We can do this with or without your consent, directly from that person or company. Our right has priority, except as otherwise provided by law. We can recover against the total amount of any recovery, regardless of whether all or part of the recovery is for medical expenses or the recovery is less than the amount needed to reimburse you fully for the illness or injury.

Personal Injury Protection/Med Pay Benefits:
You may be entitled to benefits under your own or another individual's automobile coverage, regardless of fault. These benefits are commonly referred to as Personal Injury Protection (PIP) and Medical Payments (Med Pay). Our coverage is secondary to both PIP and MedPay benefits. If we pay benefits before PIP or Med Pay benefits have been exhausted, we may recover the cost of those benefits as described above.

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

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

We have the right to be reimbursed up to the amount of any payment received by you, regardless of whether (a) all or part of the payment to you was designated, allocated, or characterized as payment for medical expenses; or (b) the payment is for an amount less than that necessary to compensate you fully for the illness or injury.

Member Cooperation:
You further agree:

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

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

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

If we pay for the costs of health care services or medications for any work-related illness or injury, we have the right to recover those costs from you, the person, or company legally obligated to pay for such services, or from the Provider. If your Provider bills services or medications to us for any work-related illness or injury, please contact Customer Relations.

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

COORDINATION OF BENEFITS

Benefits under Other Plans:
You may have benefits under other plans for hospital, medical, dental or other health care expenses.

We have a coordination of benefits program (COB) that prevents duplication of payment for the same health care services. We will coordinate benefits payable for covered services with benefits payable by other plans, consistent with state law.

Primary and Secondary Plans:
We will coordinate benefits by determining:

- Which plan has to pay first when you make a claim; and
- Which plan has to pay second.

We will make these determinations according to applicable state law.

Right to Receive and Release Necessary Information:
When you enroll, you must include information on your membership application about other health coverage you have.

After you enroll, you must notify us of new coverage or termination of other coverage. We may ask for and give out information needed to coordinate benefits.

You agree to provide information about other coverage and cooperate with our COB program.

Right to recover overpayment:
We may recover, from you or any other person or entity, any payments made that are greater than payments it should have made under the COB program. We will recover only overpayments actually made.

For more information:
For more information about COB, call Customer Relations: 1-800-701-9000.

USE AND DISCLOSURE OF MEDICAL INFORMATION

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

COVERAGE FOR PRE-EXISTING CONDITIONS

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

CIRCUMSTANCES BEYOND TUFTS HEALTH PLAN MEDICARE PREFERRED'S REASONABLE CONTROL

Circumstances Beyond our Reasonable Control:
We shall not be responsible for a failure or delay in arranging for the provision of services in cases of circumstances beyond our reasonable control. Such circumstances include, but are not limited to: major disaster; epidemic; strike; war; riot; and civil insurrection. In such circumstances, we will make a good faith effort to arrange for the provision of services. In doing so, we will take into account the impact of the event and the availability of Providers.

INDIVIDUAL CONTRACT

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

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

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

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

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

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

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

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

Note: If changes are made, they will apply to all Members enrolled in this product, not just to you.

Notices:

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

Notice to Us:
Members should address all correspondence to:

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

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

When this Policy is Issued and Effective:
This Policy is issued and effective on your Effective Date on or after January 1, 2019 and supersedes all previous Policies.

Appendix A: Glossary of Terms

TERMS AND DEFINITIONS

This section defines the terms used in this Policy

Accident
Injury or injuries for which benefits are provided means accidental bodily injury sustained by the Member which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while his or her coverage is in force under this plan.

Note: Injuries shall not include injuries for which benefits are provided or available under:

- Any workers' compensation, employer's liability or similar law;
- Motor vehicle no-fault plan;
- Or other motor vehicle insurance-related plan; unless prohibited by law.

Allowed Charge*
The expense used to determine payment of Plan benefits listed in this Policy.

- **For a service eligible for coverage under Medicare:** This means the payment amount Medicare establishes for that service. See your Medicare Handbook, or contact Medicare, for more information.
- **For a service that qualifies as a covered service under this Plan only:** This means the Provider's actual charge for that service.

**Allowed Charge does not include any Part B excess charges or sequestration charges.*

Ambulatory Surgery
Any surgical procedure(s) in an operating room under anesthesia for which the Member is admitted to a facility licensed by the state to perform surgery, and with an expected discharge the same day, or in some instances, within twenty-four hours. For hospital census purposes, the Member is an outpatient not an inpatient. Also referred to as "Ambulatory Surgery" or "Surgical Day Care."

Benefit Period
The way that Medicare measures your use of hospital and skilled nursing facility services:

- A Benefit Period **begins** the day you receive covered inpatient services in a hospital or skilled nursing facility.
- The Benefit Period **ends** when you have not received covered inpatient services in a hospital or skilled nursing care for 60 days in a row.
- If you go into the hospital after one benefit period has ended, a new benefit period begins.
- You must pay the inpatient hospital deductible for each benefit period.

There is no limit to the number of Benefit Periods you can have.

Biologically-based Mental Disorders.
The following Mental Disorders:

- Schizophrenia;
- Schizoaffective disorder;
- Major depressive disorder;
- Bipolar disorder;
- Paranoia and other psychotic disorders;
- Obsessive-compulsive disorder;
- Panic disorder;
- Delirium and dementia;
- Affective disorders;
- Eating disorders;
- Post-traumatic stress disorders;
- Autism;
- Substance abuse disorders; and any other mental disorders added by the Commissioners of the Department of Mental Health and the Division of Insurance.

Board-Certified Behavior Analyst (BCBA).
A Board-Certified Behavior Analyst (BCBA) meets the qualifications of the Behavior Analyst Certification Board (BACB) by achieving a master's degree, training, experience, and other requirements. A BCBA professional conducts behavioral assessments, designs and supervises behavior analytic interventions, and develops and implements assessment and interventions for Members with diagnoses of autism spectrum disorders. BCBAs may supervise the work of Board-Certified Assistant Behavior Analysts and other Paraprofessionals who implement behavior analytic interventions.

Coinsurance
An amount you must pay as your share of the cost of Medicare covered services after you pay any Medicare Deductibles. Coinsurance is usually a percentage (for example, 20%), rather than a set amount.

Covered Services
The services and supplies for which Tufts Health Plan Medicare Preferred will pay under this Policy must be:

- Described in Chapter 3;
- For Medicare-approved services, obtained by a Provider who accepts assignment from Medicare; and
- Except for preventive care, medically necessary.

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

Custodial Care

- Care given primarily to assist in the activities of daily living, such as bathing, dressing, eating, and maintaining personal hygiene and safety;
- Care given primarily for maintaining the Member's or anyone else's safety, when no other aspects of treatment require an acute hospital level of care;
- Services that could be given by people without professional skills or training; or
- Routine maintenance of colostomies, ileostomies, and urinary catheters; or
- Adult and pediatric day care.
- In cases of mental health care when no other aspects of treatment require an acute hospital level of care, inpatient care given primarily:
  - For maintaining the Member's or anyone else's safety, or
  - For the maintenance and monitoring of an established treatment program,

Note: Custodial care is **not** covered by Tufts Health Plan Medicare Preferred.

Deductible

The amount you must pay for health care, before Medicare begins to pay for Medicare covered services. There is a deductible for each benefit period for Part A, and each year for Part B. These amounts can change every year.

Durable Medical Equipment

Devices or instruments of a durable nature that:

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

Effective Date

This is the date which according to our records you become a Member and are first eligible for covered services.

Emergency

An illness or medical condition, whether physical or mental, that manifests itself by symptoms of sufficient severity including severe pain that the absence of prompt medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine, to result in:

- Serious jeopardy to the physical and / or mental health of a Member or another person (or with respect to a pregnant Member, the Member's or her unborn child's physical and / or mental health);
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part; or
- With respect to a pregnant woman who is having contractions, inadequate time to effect a safe transfer to another hospital before delivery, or a threat to the safety of the Member or her unborn child in the event of transfer to another hospital before delivery.

Some examples of illnesses or medical conditions requiring emergency care are: severe pain; a broken leg; loss of consciousness; vomiting blood; chest pain; difficulty breathing; or any medical condition that is quickly getting much worse.

Experimental or Investigative
A service, supply, treatment, procedure, device, or medication (collectively "treatment") is considered Experimental or Investigative, and therefore not Medically Necessary if any of the following is true:

- The drug or device cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished or to be furnished;
- The treatment, or the "informed consent" form used with the treatment, was reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or federal law requires such review or approval;
- Reliable scientific evidence shows that the treatment is the subject of ongoing Phase I or Phase II clinical trials; is the research, experimental, study or investigative arm of ongoing Phase III clinical trials; or is otherwise under study to determine its safety, efficacy, toxicity, maximum tolerated dose, or its efficacy as compared with a standard means of treatment or diagnosis;
- Evaluation by an independent health technology assessment organization has determined that the treatment is not proven safe and/or effective in improving health outcomes or that appropriate patient selection has not been determined;
- The peer-reviewed published literature regarding the treatment is predominantly non-randomized, historically controlled, case controlled, or cohort studies, or there are few or no well-designed randomized, controlled trials;
- There is no scientific or clinical evidence that the treatment is at least as beneficial as any established, evidence-based alternatives.

Hospital
A hospital, as defined by Medicare, which is authorized for payment by Medicare and licensed to operate as a hospital in the state where it operates.

Individual Contract
The agreement between Tufts Health Plan Medicare Preferred and you under which:

- We agree to provide Individual Coverage to you; and
- You agree to pay a Premium to us on your behalf.

The Individual Contract includes this Policy and any amendments.

Inpatient
A patient who is:

- Admitted to a hospital or other facility licensed to provide continuous care; and
- Classified as an inpatient for all or a part of the day on the facility's inpatient census.

Medically Necessary

- **For a service eligible for coverage under Medicare:** This means "medically necessary" as determined by Medicare. See your Medicare Handbook or contact Medicare for more information.
- **For a service that qualifies as a covered service under this Tufts Health Plan Medicare Preferred Medicare Supplement Policy only:** This term has the following meaning:

  A service or supply that is consistent with generally accepted principles of professional medical practice as determined by whether that service or supply:
  - Is the most appropriate available supply or level of services for the Member in question considering potential benefits and harms to that individual;
  - Is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or
  - For services and interventions not in widespread use, is based on scientific evidence.

  In determining coverage for medically necessary Services, Tufts Health Plan Medicare Preferred uses Medical Necessity Guidelines which are:
  - Developed with input from practicing physicians;
  - Developed in accordance with the standards adopted by national accreditation organizations;
  - Updated at least biennially or more often as new treatments, applications and technologies are adopted as generally accepted professional medical practice; and
  - Evidence-based, if practicable.

Medicare

Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare-approved Amount

The amount a Physician or supplier that accepts assignment can be paid by Medicare.

- It includes what Medicare pays and any deductible, coinsurance, or copayment that you pay.
- It may be less than the actual amount a doctor or supplier charges.

Medicare Eligible Expenses

Expenses of the kind covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

Member

A person who:

- Enrolls in the Plan;
- Signs the membership application form; and
- In whose name the Premium is paid to us.

Also, referred to as "you."

Mental Disorders

Psychiatric illnesses or diseases listed as Mental Disorders in the latest edition, at the time treatment is given, of the American Psychiatric Association's Diagnostic and Statistical Manual: Mental Disorders regardless of whether the cause of the illness or disease is organic.

Non-Conventional Medicine
A group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine and are generally not based on scientific evidence. Since these services are not based on scientific evidence, they do not meet the Tufts Health Plan definition of Medical Necessity and are not covered. Providers of these non-covered services may be contracting or non-contracting traditional medical providers. These services may be offered in connection with a traditional office visit. Providers of Non-Convention Medicine services often request payment up front because health insurance typically does not cover these services.

Common terminology used to refer to these types of services include, but are not limited to, "alternative medicine", "complementary medicine", "integrative medicine", "functional health medicine", and may be described as treating "the whole person", "the entire individual", or "the inner self", and may refer to re-balancing hormones or finding underlying causes that lead to bodily dysfunction. Examples of Non-Conventional Medicine and related services include, but are not limited to:

- Holistic, naturopathic, energy medicine (e.g., Reiki, Ayurvedic, magnetic fields);
- Manipulative and body-based practices (e.g., reflexology, yoga, exercise therapy, tai-chi);
- Mind-body medicine (e.g., hypnotherapy, meditation, stress management);
- Whole medicine systems (e.g., naturopathy, homeopathy);
- Biologically based practices (e.g., herbal medicine, dietary supplements, probiotics); and
- Other related practices when provided in connection with Non-Conventional Medicine services (e.g., animal therapy, art therapy, dance therapy, sleep therapy, light therapy, energy-balancing, breathing exercises).

Outpatient
A patient who receives care that is not provided on an inpatient basis. This includes services provided in:

- A physician's office;
- An ambulatory surgical center; and
- An emergency room or outpatient clinic.

Paraprofessional
As it pertains to the treatment of autism and autism spectrum disorders, a Paraprofessional is an individual who performs applied behavior analysis (ABA) services under the supervision of a Board-Certified Behavior Analyst (BCBA).

Physician
As defined by Medicare, an individual licensed under state law to practice:

- Medicine; or
- Osteopathy.

Plan
The Tufts Health Plan Medicare Preferred Medicare Supplement option described in this Policy.

Policy
This document, and any future amendments, which describes the Plan in which you have enrolled. This Policy is the agreement for the coverage under the Plan between: you; and Tufts Health Plan Medicare Preferred.

Premium
The total monthly cost of Individual Coverage which the Member pays to Tufts Health Plan Medicare Preferred.

Provider
A health care professional or facility licensed in accordance with applicable law. Providers do not have to contract with Tufts Health Plan Medicare Preferred in order to offer services for the benefits listed in this Policy.

The types of Providers covered under the Plan include, but are not limited to: ambulatory surgical centers; hospitals; physicians; physician assistants; certified nurse midwives; certified registered nurse anesthetists; nurse practitioners; optometrists; podiatrists; psychologists; licensed mental health counselors; licensed independent clinical social workers; licensed drug and alcohol counselors I; licensed marriage and family therapists; and skilled nursing facilities.

The Plan will only cover services of a Provider, if those services are:
- Listed as covered services; and
- Within the scope of the Provider's license.

Important Note—Providers outside of Massachusetts:
No coverage is available under this Plan for services obtained by the following types of Providers **outside of Massachusetts**:
- Clinical specialists in psychiatric and mental health nursing;
- Licensed independent clinical social workers (for covered services under this Plan only);
- Licensed mental health counselors; and
- Psychologists (for covered services under this Plan only).

Rape-related Mental or Emotional Disorder
A mental or emotional disorder related to a Member who is a victim of rape or assault with intent to commit rape.

Rape-related Mental or Emotional Disorders are covered when the costs for treatment exceed the maximum amount awarded under applicable Massachusetts law.

Reserve Days
Sixty days that Medicare will pay for when you are put in a hospital for more than 90 days of Medicare covered services. These 60 reserve days can be used only once during your lifetime. For each lifetime Reserve Day, Medicare pays all covered costs except for a daily coinsurance amount.

Sickness
An illness or disease of a Member for which expenses are incurred after the Effective Date and while the insurance is in force.

Note: Sicknesses shall not include sicknesses for which benefits are provided or available under any workers' compensation, employer's liability or similar law, motor vehicle no-fault plan, or other motor vehicle insurance-related plan, unless prohibited by law.

Skilled
A type of care which is medically necessary and must be provided by, or under the direct supervision of, licensed medical personnel. Skilled care is provided to achieve a medically desired and realistically achievable outcome.

Skilled Nursing Facility
A Medicare-certified Skilled Nursing Facility with the staff and equipment to provide: skilled nursing care and/or skilled rehabilitation services; and other related health services.

Tufts Health Plan/Tufts Medicare Preferred.
Tufts Insurance Company (TIC), a Massachusetts corporation d/b/a Tufts Health Plan Medicare Preferred. Also referred to as: "we;" "us;" or "our."

Urgent Care
Care provided when your health is not in serious danger, but you need immediate medical attention for an unforeseen illness or injury. Examples of illnesses or injuries in which urgent care might be needed are: a broken or dislocated toe; a cut that needs stitches but is not actively bleeding; sudden extreme anxiety; or symptoms of a urinary tract infection.

Note: Care is not considered Urgent Care if it is rendered:

- After the Urgent condition has been treated and stabilized;
- And the Member is safe for transport.