Tufts Health Plan Medicare Preferred Medicare Supplement Description of Benefits

Tufts Medicare Preferred Group Supplement 6 Plan

With Administrative Services Provider by

705 Mount Auburn Street, Watertown, MA 02472-1508

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Tufts Health Plan Medicare Preferred Address And Telephone Directory

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.

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

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

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

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

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

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

Massachusetts Relay (MassRelay):
711.

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.

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 Customer Relations, 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

TRANSLATING SERVICES FOR MORE THAN 200 LANGUAGES

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

For no cost translation in English, call the number on your ID card.

Arabic للحصول على خدمة الترجمة المجانية باللغة العربية، يرجى الاتصال على الرقم المدون على بطاقة الهوية الخاصة بك.

Chinese 若需免費的中文版本，請撥打ID卡上的電話號碼。

French Pour demander une traduction gratuite en français, composez le numéro indiqué sur votre carte d'identité.

Greek Για δωρεάν μετάφραση στα Ελληνικά, καλέστε τον αριθμό που αναγράφεται στην αναγνωριστική κάρτας σας.

Gujarati વિના ખર્ચે ગુજરાતીમાં અનુવાદ માટે, આપના આઇડી કાર્ડમાં દર્શાવેલ નંબર પર કોલ કરો.

Haitian Creole Pou jwenn tradiksyon gratis nan lang Kreyòl Ayisyen, rele nimewo ki sou kat ID ou.

Hindi हिन्दी में बिना मूल्य अनुवाद के लिए, अपने आईडी कार्ड पर दिये गए नंबर पर कॉल करें।

Italian Per la traduzione in italiano senza costi aggiuntivi, è possibile chiamare il numero indicato sulla tessera identificativa.

Khmer សម្រាប់សេវាបកប្រែដោយឥតគិតថ្លៃជា ភាសាខ្មែរ
សូមទូរស័ព្ទទៅកាន់លេខដែលមាននៅលើប័ណ្ណសម្គាល់សមាជិករបស់អ្នក។

Korean 한국어로 무료 통역을 원하시면, ID 카드에 있는 번호로 연락하십시오.

Laotianສໍາລັບການແປພາສາເປັນພາສາລາວທີ່ບໍ່ໄດ້ເສຍຄ່າໃຊ້ຈ່າຍ, ໃຫ້ໂທຫາເບີທີ່ຢູ່ເທິງບັດປະຈໍາຕົວຂອງທ່ານ.

Polish Aby uzyskać bezpłatne tłumaczenie w języku polskim, należy zadzwonić na numer znajdujący się na Pana/i dowodzie tożsamości.

Portuguese Para tradução grátis para português, ligue para o número no seu cartão de identificação.

Russian Для получения услуг бесплатного перевода на русский язык позвоните по номеру, указанному на идентификационной карточке.

Spanish Por servicio de traducción gratuito en español, llame al número de su tarjeta de miembro.

Tagalog Para sa walang bayad na pagsasalin sa Tagalog, tawagan ang numero na nasa inyong ID card.

Vietnamese Để có bản dịch tiếng Việt không phải trả phí, gọi theo số trên thẻ căn cước của bạn.

TTY Telecommunications Device for the Deaf: 711.

Table of Contents

Table of Contents

Chapter 1: How Your Plan Works

OVERVIEW

Introduction:

This booklet contains your Description of Benefits. It describes your Group's health benefits Plan, which is referred to here as the "Plan." This is a self-funded Plan, which means your Group is responsible for the cost of the Covered Services you receive under it. The Group has contracted with Tufts Health Plan Medicare Preferred. We offer a Medicare Supplement option and perform certain services for the Plan, such as claims processing and enrollment. We do not, however, insure the Plan benefits or determine your eligibility for benefits under the Plan. This is the Plan's responsibility.

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.

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.

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 Description of Benefits:

This book, called your Description of Benefits, 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 Description of Benefits that are

- Eligible for coverage under Medicare, or
- Eligible for coverage under the Plan, when Medically Necessary

Certain benefits described in this Description of Benefits are consistent with the requirements of 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 Description of Benefits 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:
Tufts Health Plan Medicare Preferred 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.

Chapter 2: 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 Parts A and 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 meet your Group's eligibility rules
  - 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:

If Tufts Health Plan Medicare Preferred accepts your application and receives the needed contribution from you, your coverage starts on the date chosen by your Group.

Chapter 3: Benefit Schedule and Covered Services

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 Description of Benefits.

The Covered Services section of this chapter describes the health care services and supplies that qualify as Covered Services under this Description of Benefits. Read this section to understand your coverage under this Tufts Health Plan Medicare Preferred Medicare Supplement option. In addition, this chapter explains the services and supplies excluded under this Description of Benefits. 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.

The following footnote applies to all pages in chapter 3.

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

Ambulance Services		
Medicare Pays	**Tufts Medicare Preferred Supplement Pays**	**You Pay***
Medicare benefits in full, except: • The Part B Deductible • The Part B Coinsurance	…the following charges, minus a $50 Copayment per day: • The Part B Deductible • The Part B Coinsurance	• A $50 Copayment per day
Tufts Medicare Preferred Supplement Covered Services		
Once Medicare provides coverage, The Plan 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		

Autism Spectrum Disorders – Diagnosis and Treatment		
Medicare Pays	**Tufts Medicare Preferred Supplement 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 Deductible • 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: • Nothing When not covered by Medicare: • Nothing, for rehabilitative or habilitative care • All charges for all other services

Chapter 3: Benefit Schedule and Covered Services

Tufts Medicare Preferred Supplement Covered Services

Coverage is provided, in accordance with applicable 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 to 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.

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 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 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. **Note:** The Inpatient blood deductible will apply to you only if the Hospital or Skilled Nursing Facility has to purchase the blood for you for your Inpatient admission. In this case, this deductible will be waived if you either replace the blood yourself or have it donated by another party. See also Blood Services – Outpatient. You are responsible for only paying one blood deductible under Medicare Part A or Part B per calendar year.		

Blood Services – Outpatient		
Medicare Pays	**Tufts Medicare Preferred Supplement Pays**	**You Pay***
Medicare benefits in full, except • The blood deductible	• The blood deductible	• Nothing
Tufts Medicare Preferred Supplement 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 Pays**	**You Pay***
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 Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for Medicare-approved Outpatient cardiac rehabilitation services.		

Chemotherapy		
Medicare Pays	**Tufts Medicare Preferred Supplement 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 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 Pays**	**You Pay***
Medicare benefits in full, except: • The Part B Deductible • The Part B Coinsurance	The following charges, minus a $15 Copayment per visit: • The Part B Deductible • The Part B Coinsurance	• A $15 Copayment per visit
Tufts Medicare Preferred Supplement 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.		

Diabetic Services and Supplies		
Medicare Pays	**Tufts Medicare Preferred Supplement 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	When covered by Medicare: • The Part B Deductible • The Part B Coinsurance When not covered by Medicare: • Nothing	When covered by Medicare: • Nothing When not covered by Medicare: • All charges
Tufts Medicare Preferred Supplement 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 Pays**	**You Pay***
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 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.		

Dialysis (Kidney) Services and Supplies		
Medicare Pays	**Tufts Medicare Preferred Supplement Pays**	**You Pay***
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 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 Pays**	**You Pay***
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 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 Pays**	**You Pay***
Medicare benefits in full, except: • The Part B Deductible • The Part B Coinsurance	The following charges, minus a $75 Copayment per visit: • The Part B Deductible • The Part B Coinsurance	• A $75 Copayment per visit

Tufts Medicare Preferred Supplement Covered Services
Once Medicare approves the coverage, the Plan provides coverage up to the Allowed Charge for Medicare-approved Emergency room care. You do not pay the Copayment if you are admitted as an Inpatient to the Hospital within 24 hours for the same condition. **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. For information about obtaining Emergency care and Urgent Care services outside the United States, please see "Foreign Travel ."

Enteral Formulas, Low-Protein Food Products		
Medicare Pays	**Tufts Medicare Preferred Supplement 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	When covered by Medicare: • The Part B Deductible • The Part B Coinsurance 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 covered by Medicare: • Nothing 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 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.

Foreign Travel		
Medicare Pays	**Tufts Medicare Preferred Supplement 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	• The appropriate cost share depending on the services rendered
Tufts Medicare Preferred Supplement 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 Description of Benefits • The benefits that Medicare normally provides that are listed in this Description of Benefits **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 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 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.		

Hospice Care		
Medicare Pays	**Tufts Medicare Preferred Supplement Pays**	**You Pay***
When covered by Medicare: • Medicare benefits in full for most services When not covered by Medicare: • Nothing	When Medicare does not provide benefits in full: • The difference between the amount Medicare pays and the Allowed Charge When not covered by Medicare: • Covered Services in full	When covered by Medicare: • Nothing When not covered by Medicare: • Nothing
Tufts Medicare Preferred Supplement 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 applicable 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		

Hospital Medical and Surgical Care – Inpatient (Including Care for Biologically-based Mental Disorders)		
Medicare Pays	**Tufts Medicare Preferred Supplement 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 following charges, minus a $50 copayment per admission to a general hospital, up to a calendar year maximum of $200: • 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 • Covered Services in full up to an additional 365 days per lifetime** after Medicare benefits are used up	Per Benefit Period: $50 Copayment per admission to a general Hospital up to $200 per calendar year, then: • Nothing for days 1-90 • 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 Deductible • The Part B Coinsurance	• Nothing
Tufts Medicare Preferred Supplement 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 covered only for semi-private room and board charges.		

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

Hospital Medical and Surgical Care - Outpatient (including Ambulatory Surgical Centers)		
Medicare Pays	**Tufts Medicare Preferred Supplement 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 following charges, minus a $50 Copayment per day: • The Part B Deductible • The Part B Coinsurance	• A $50 Copayment per visit
Medicare benefits in full for Physician and other professional Provider services, except: • The Part B Deductible • The Part B Coinsurance	…the following charges, minus a $15 Copayment per day: • The Part B Deductible • The Part B Coinsurance	• A $15 Copayment per visit
Tufts Medicare Preferred Supplement 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).		

Human Organ Transplants		
Medicare Pays	**Tufts Medicare Preferred Supplement 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 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 Pays**	**You Pay***
Medicare benefits in full, except: • The Part B Deductible • The Part B Coinsurance	The following charges, minus a $15 Copayment per visit: • The Part B Deductible • The Part B Coinsurance	• A $15 Copayment per visit
Tufts Medicare Preferred Supplement 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 Note: This benefit includes coverage for psychopharmacological services neuropsychological assessment services.		

Mental Health and Substance Abuse Services		
Medicare Pays	**Tufts Medicare Preferred Supplement 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 Deductible for days 1-60 • 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: • Nothing for days 1-90 • 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 Deductible • The Part B Coinsurance • Covered in full for covered benefits provided only by the Plan	Inpatient Physician and other covered professional mental health Provider services: • Nothing for as many days as Medically Necessary
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 following charges, minus a $15 Copayment per visit: • The Part B Deductible • The Part B Coinsurance • Covered in full for covered benefits provided only by the Plan	Outpatient treatment for as many days as Medically Necessary: • A $15 Copayment per visit

***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 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 Deductible for days 1-60 • 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: • Nothing for days 1-90 • 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 Deductible for days 1-60 • 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 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: • Nothing for days 1-90 • Nothing for up to 60 lifetime Reserve Days • Covered Services up to 120 days per Benefit Period in a mental Hospital • Then, all charges

***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 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 Deductible • 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 in a mental Hospital when covered only by the Plan	Inpatient Physician and other covered professional mental health Provider services • Nothing for as many days as Medically Necessary
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 following charges, minus a $15 Copayment per visit: • The Part B Deductible • The Part B Coinsurance • Covered Services in full when covered only by the Plan	Outpatient treatment for as many visits as Medically Necessary • A $15 Copayment per visit for Medicare and Plan benefits for as many visits as Medically Necessary • A $15 Copayment per visit when covered only by the Plan

Mental Health and Substance Abuse Services continued

Tufts Medicare Preferred Supplement 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

Note: Psychopharmacological services and neuropsychological assessment services are covered as medical benefits.

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.

Mental Health and Substance Abuse Services continued

Tufts Medicare Preferred Supplement 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. 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.

Opioid treatment program services		
Medicare Pays	**Tufts Medicare Preferred Supplement Pays**	**You Pay***
Medicare Part B benefits for Opioid treatment program services covered in full	• Nothing	• Nothing
Tufts Medicare Preferred Supplement Covered Services		
Opioid use disorder treatment services are covered. Covered Services include: • FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable • Substance use counseling • Individual and group therapy • Toxicology testing		

Oxygen and Equipment		
Medicare Pays	**Tufts Medicare Preferred Supplement Pays**	**You Pay***
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 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 Pays**	**You Pay***
Medicare benefits in full, except: • The Part B Deductible • The Part B Coinsurance	The following charges, minus a • $15 Copayment per visit: • The Part B Deductible • The Part B Coinsurance	• A $15 Copayment per visit
Tufts Medicare Preferred Supplement 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.		

Prescription Drugs – Limited Outpatient Drug Coverage under Medicare Part B		
Medicare Pays	**Tufts Medicare Preferred Supplement 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 Deductible • The Part B Coinsurance	When covered by Medicare, • Nothing
Tufts Medicare Preferred Supplement 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 – Abdominal aortic aneurysm screening:		
Medicare Pays	**Tufts Medicare Preferred Supplement Pays**	**You Pay***
Medicare benefits in full for Abdominal aortic aneurysm screening	• Nothing	• Nothing
Tufts Medicare Preferred Supplement Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for a one-time screening ultrasound for people at risk. The Plan only covers this screening if you have certain risk factors and if you get a referral for it from your Physician, physician assistant, nurse practitioner, or clinical nurse specialist.		

Preventive Care – Alcohol Screening and counseling to reduce alcohol misuse:		
Medicare Pays	**Tufts Medicare Preferred Supplement Pays**	**You Pay***
Medicare benefits in full for Alcohol Screening and counseling to reduce alcohol misuse	• Nothing	• Nothing
Tufts Medicare Preferred Supplement Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but are not alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified Primary Care doctor or practitioner in a Primary Care setting.		

Preventive Care – Annual Prostate Cancer Screenings		
Medicare Pays	**Tufts Medicare Preferred Supplement 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 Deductible • The Part B Coinsurance	• Nothing • Nothing

Tufts Medicare Preferred Supplement 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.		

Preventive Care – Annual Screening Mammograms		
Medicare Pays	**Tufts Medicare Preferred Supplement Pays**	**You Pay***
Medicare benefits in full for annual screening mammogram	• Nothing	• Nothing
Tufts Medicare Preferred Supplement 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 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 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 Pays**	**You Pay***
Medicare benefits in full for screening bone mass density testing	• Nothing	• Nothing
Tufts Medicare Preferred Supplement 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 Pays**	**You Pay***
Medicare benefits in full for routine cardiovascular screening	• Nothing	• Nothing
Tufts Medicare Preferred Supplement 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 Pays**	**You Pay***
Medicare benefits for as follow 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	• Nothing	• Nothing
• Barium enema covered, subject to: • The Part B Deductible • The Part B Coinsurance	• The Part B Deductible • The Part B Coinsurance	• Nothing

Preventive Care – Colorectal Cancer Screenings continued
Tufts Medicare Preferred Supplement Covered Services
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for the following routine colorectal cancer services for Members 50 and older: • 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 Members 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 – Depression screening:		
Medicare Pays	**Tufts Medicare Preferred Supplement Pays**	**You Pay***
Medicare benefits for Depression screening in full for annual Depression screening	• Nothing	• Nothing
Tufts Medicare Preferred Supplement Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for a Depression screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.		

Preventive Care – Diabetes Self-Management Training		
Medicare Pays	**Tufts Medicare Preferred Supplement Pays**	**You Pay***
Medicare benefits in full for diabetes self-management training, except: • The Part B Deductible • The Part B Coinsurance	• The Part B Deductible • The Part B Coinsurance	• Nothing
Tufts Medicare Preferred Supplement 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.		

Preventive Care – Family Planning		
Medicare Pays	**Tufts Medicare Preferred Supplement Pays**	**You Pay***
For family planning: • Nothing	• Benefits in full as required by state mandate	• Nothing
Tufts Medicare Preferred Supplement 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 Pays**	**You Pay***
Medicare benefits in full for glaucoma testing, except: • The Part B Deductible • The Part B Coinsurance	• The Part B Deductible • The Part B Coinsurance	• Nothing
Tufts Medicare Preferred Supplement 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.		

Preventive Care – HIV Screening:		
Medicare Pays	**Tufts Medicare Preferred Supplement Pays**	**You Pay***
Medicare benefits in full for HIV screening	• Nothing	• Nothing
Tufts Medicare Preferred Supplement Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for HIV screening. • For people who ask for an HIV screening test or who are at increased risk for HIV infection, one screening exam every 12 months • For women who are pregnant, up to three screening exams during a pregnancy		

Preventive Care – Immunizations:		
Medicare Pays	**Tufts Medicare Preferred Supplement Pays**	**You Pay***
Medicare Part B services benefits in full for Immunizations	• Nothing	• Nothing
Tufts Medicare Preferred Supplement Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for Immunizations: • Pneumonia / pneumococcal vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if Medically Necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover some vaccines under our Part D prescription drug benefit.		

Preventive Care – Medicare Diabetes Prevention Program (MDPP)		
Medicare Pays	**Tufts Medicare Preferred Supplement 2 Pays**	**You Pay***
Medicare benefits in full for the Medicare Diabetes Prevention Program	• Nothing	• Nothing
Tufts Medicare Preferred Supplement 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 – Medical Nutrition Therapy		
Medicare Pays	**Tufts Medicare Preferred Supplement Pays**	**You Pay***
Medicare benefits in full for Medical Nutrition Therapy	• Nothing	• Nothing
Tufts Medicare Preferred Supplement 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 – Obesity Screening and Therapy to Promote Sustained Weight Loss:		
Medicare Pays	**Tufts Medicare Preferred Supplement Pays**	**You Pay***
Medicare benefits in full for Obesity screening and therapy to promote sustained weight loss	• Nothing	• Nothing
Tufts Medicare Preferred Supplement Covered Services		
If you have a body mass index of 30 or more, Medicare covers intensive counseling to help you lose weight. This counseling is covered if you get it in a Primary Care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your Primary Care doctor or practitioner to find out more.		

Preventive Care – Pelvic and Clinical Breast Exams and Routine Cytology Exam (Pap Smear)		
Medicare Pays	**Tufts Medicare Preferred Supplement 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 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.		

Preventive Care – Screening for Lung Cancer with Low Dose Computed Tomography (LDCT)		
Medicare Pays	**Tufts Medicare Preferred Supplement Pays**	**You Pay***
Medicare benefits in full for screening for lung cancer with low dose computed tomography (LDCT)	• Nothing	• Nothing
Tufts Medicare Preferred Supplement 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.		

Preventive Care – Screening for sexually transmitted infections (STIs) and counseling to prevent STIs:		
Medicare Pays	**Tufts Medicare Preferred Supplement Pays**	**You Pay***
Medicare Part B benefits in full for Screening for sexually transmitted infections (STIs) and counseling to prevent STIs	• Nothing	• Nothing
Tufts Medicare Preferred Supplement Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for screening for sexually transmitted infections (STIs) and counseling to prevent STIs. We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care Provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a Primary Care Provider and take place in a primary care setting, such as a doctor's office.		

Preventive Care – Smoking and Tobacco Use Cessation Counseling		
Medicare Pays	**Tufts Medicare Preferred Supplement 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 following charges, minus a $15 Copayment per visit: • The Part B Deductible • The Part B Coinsurance	• A $15 Copayment per visit
Tufts Medicare Preferred Supplement 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 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 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.		

Pulmonary Rehabilitation Services:		
Medicare Pays	**Tufts Medicare Preferred Supplement Pays**	**You Pay***
Medicare benefits for Pulmonary Rehabilitation Services in full, **except**: • The Part B Deductible • The Part B Coinsurance	• The Part B Deductible • The Part B Coinsurance	• Nothing
Tufts Medicare Preferred Supplement Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for comprehensive programs of pulmonary rehabilitation are covered for Members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.		

Radiation and X-ray Therapy		
Medicare Pays	**Tufts Medicare Preferred Supplement Pays**	**You Pay***
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 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 Pays**	**You Pay***
Medicare benefits in full, except: • The Part B Deductible • The Part B Coinsurance	The following charges, minus a $15 Copayment per visit: • The Part B Deductible • The Part B Coinsurance	• A $15 Copayment per visit
Tufts Medicare Preferred Supplement 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 Pays**	**You Pay***
Medicare benefits in full, except: • The Part B Deductible • The Part B Coinsurance	…the following charges, minus a $15 Copayment per visit: • The Part B Deductible, • The Part B Coinsurance	• A $15 Copayment per visit
Tufts Medicare Preferred Supplement 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.		

Skilled Nursing Facility Services		
Medicare Pays	**Tufts Medicare Preferred Supplement 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 days 101-365 • Nothing for days 366 and beyond	Per Benefit Period: • Nothing; • The Part A Coinsurance • $10 per day in a Skilled Nursing Facility participating with Medicare • $8 per day in a Skilled Nursing Facility not participating with Medicare • Nothing	Per Benefit Period: • Nothing • Nothing • Balance • Balance • All costs

Tufts Medicare Preferred Supplement 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. After that, the Plan provides coverage as follows:

- Services from Skilled Nursing Facility participating with Medicare for 101st through 365th day in a Benefit Period: The Plan pays $10 per day for each of these days.
- Services from Skilled Nursing Facility *not* participating with Medicare for 101st through 365th day in a Benefit Period: The Plan pays $8 per day for each of these days.

Note: Medicare and the Plan both provide coverage for Skilled Nursing Facility services, when a Member's Inpatient stay in such a facility meets Medicare's rules. 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 Pays**	**You Pay***
Medicare benefits in full, except: • The Part B Deductible • The Part B Coinsurance	• As described under Hospital Medical and Surgical Care – Outpatient	• As described under Hospital Medical and Surgical Care – Outpatient
Tufts Medicare Preferred Supplement Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for Medicare-approved Outpatient surgery.		

Telehealth Services:		
Medicare Pays	**Tufts Medicare Preferred Supplement Pays**	**You Pay***
Medicare benefits in full for Telehealth Services, **except**: • The Part B Deductible • The Part B Coinsurance	The following charges, minus a $15 Copayment per visit: • The Part B Deductible • The Part B Coinsurance	A $15 Copayment per visit
Tufts Medicare Preferred Supplement Covered Services		
The Plan provides coverage up to the Allowed Charge for services like office visits, psychotherapy, consultations, and certain other medical or health services provided by an eligible Provider who isn't at your location using an interactive, two-way telecommunications system (like real-time audio and video). For most of these services, you'll pay the same amount that you would if you got the services in person.		

Urgently needed care:		
Medicare Pays	**Tufts Medicare Preferred Supplement Pays**	**You Pay***
Medicare benefits for Urgently needed care in full, **except**: • The Part B Deductible • The Part B Coinsurance	The following charges, minus a $15 Copayment per visit: • The Part B Deductible • The Part B Coinsurance	• A $15 Copayment per visit
Tufts Medicare Preferred Supplement Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for urgently needed care services. These services are provided to treat a non-Emergency, unforeseen medical illness, injury, or condition that requires immediate medical care.		

Vision Care:		
Medicare Pays	**Tufts Medicare Preferred Supplement Pays**	**You Pay***
Medicare benefits in full for Vision Care services, **except:** • The Part B Deductible • The Part B Coinsurance The services covered under this benefit are:	The following charges, minus the amounts shown for the items below: • The Part B Deductible • The Part B Coinsurance	The amounts shown for the items below:
• Eyewear after Cataract Surgery	• Nothing	• Nothing
• Medicare covered exams	• All charges, minus a $15 Copayment per visit	• A $15 Copayment per visit
• Annual routine eye exam	• All charges, minus a $15 Copayment per visit every 24 months	• A $15 Copayment per visit every 24 months
• Annual routine glasses, contacts	• All charges, up to $150 per calendar year	• All charges above $150 per calendar year

Tufts Medicare Preferred Supplement Covered Services

The Plan provides coverage up to the Allowed Charge for the following:

- Outpatient Physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration
- For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older and Hispanic Americans who are 65 or older.
- For people with diabetes, screening for diabetic retinopathy is covered once per year.
- One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.)

Women's Health and Cancer Rights Act Coverage		
Medicare Pays	**Tufts Medicare Preferred Supplement 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 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 Pays**	**You Pay***
• Routine physical exam: covered for one exam per calendar year	• All charges	• Nothing
• Routine hearing exam: covered for one exam per calendar year	• All charges for one annual exam, minus a $15 Copayment for the exam	• A $15 Copayment for the exam
• Routine eye exam: covered for one exam every 24 months	• All charges for one exam every 24 months, minus a $15 Copayment for the exam	• A $15 Copayment for the exam
• Eyeglasses (including lenses and frames) or Contact Lenses: covered up to a combined maximum benefit of $150 per calendar year	• All combined charges up to $150 per calendar year	• All costs, after the maximum benefit of up to $150 per calendar year is reached
• Fitness and Nutritional Counseling Benefit	• All combined charges up to a maxi- mum benefit of $150 per calendar year	• All costs, after the maximum benefit of up to $150 per calendar year is reached
• Weight Management Programs	• The Plan will cover program fees for weight loss programs such as Weight Watchers, Jenny Craig, or a Hospital-based weight loss program. This benefit does not cover costs for pre-packaged meals/foods, books, videos, scales, or other items or supplies.	• The Plan will reimburse Members up to an annual maximum of $150 towards program fees for weight loss programs.
• Hearing aids (other than Hearing aids for children age 21 and under): described below: covered up to a maximum benefit of $1,700 in each 24-month period	• The first $500 of a covered hearing aid and then 80% of the next $1,500. Coverage is provided up to a maximum benefit of $1,500 in each 24-month period	• After the first $500 paid by Tufts Health Plan Medicare Supplement, 20% of the next $1,500 for a covered hearing aid. You also pay any balance over that $1,500.

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 Pays**	**You Pay***
• Hearing aids for children age 21 and under in accordance with applicable law. See Covered Services below	• All charges. Coverage is provided for hearing aids up to a maximum benefit of $2,000 per year every 36 months	• All costs, after the maximum benefit of up to $2,000 per ear every 36 months is reached
• Scalp hair prostheses worn for hair loss suffered due to the treatment of any form of cancer or leukemia	• All charges up to a maximum benefit of $350 per calendar year	• All costs, after the maximum benefit of up to $350 per calendar year is reached
• Cleft lip or cleft palate treatment and services for children, in accordance with applicable law	• All charges	• Nothing
• Outpatient substance services for medication-assisted treatment, including methadone maintenance	• All charges, minus a $15 Copayment per visit	• A $15 Copayment per visit
• 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, minus a $15 Copayment per visit	• A $15 Copayment per visit

Tufts Medicare Preferred Supplement Covered Services

The Plan provides coverage up to the Allowed Charge for the following services and supplies:

Routine physical exam:

Covers one annual exam

Routine hearing exam:

Covers one annual exam

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

Tufts Medicare Preferred Supplement Covered Services

Routine eye exam:
The Plan covers one routine vision exam every 24 months to find out if you need corrective lenses, when the exam is furnished by any licensed ophthalmologist or optometrist.

Eye glasses (including lenses and frames) or Contact Lenses:
The Plan covers up to $150 every calendar year for one set of frames and prescription lenses or contact lenses (in place of eyeglasses) from any licensed vision care supplier. This $150 benefit payment includes costs for measurement, fitting, and adjustments. No coverage is provided for: amounts more than $150 every calendar year; non-prescription lenses; sunglasses that do not require a prescription; safety glasses; replacement of lost or broken frames or lenses; and special procedures such as vision training and subnormal vision aids and similar procedures and devices.

To obtain up to the $150 Eyewear reimbursement, please submit a claim form along with an itemized bill from the licensed vision care supplier 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 March 31st of the following year.

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. (This is a combined benefit)

Important notes about this benefit:

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

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

Tufts Medicare Preferred Supplement Covered Services

Weight Management Programs benefit:

- The Plan will cover program fees for weight loss programs such as WeightWatchers, Jenny Craig,
- or a Hospital-based weight loss program. This benefit does not cover costs for pre-packaged meals/foods, books, videos, scales, or other items or supplies.
- To obtain up to the $150 Weight Management Programs reimbursement, please submit a claim form along with an itemized bill from the weight management program 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.

Hearing aids:

Covered up to a maximum benefit of $1,700 in each 24-month period. Tufts Health Plan Medicare Supplement Pays the first $500, and then 80% of the next $1,500, for a covered hearing aid. You pay the remaining 20% of that $1,500, as well as any balance over that amount. Coverage under this benefit includes hearing aids, including the fitting of the hearing aid, when prescribed by a Physician and obtained from a hearing aid supplier. When there is a pathological change in the Member's hearing or the hearing aid is lost, benefits for a replacement hearing aid are also covered subject to the benefit maximum.

Hearing aids for Children:

In accordance with applicable 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

Wigs:

The Plan will pay for scalp hair prostheses worn for hair loss suffered due to the treatment of any form of cancer or leukemia. The Plan provides this coverage up to a maximum of $350 per person in a calendar year.

To the extent not covered by Medicare, the Plan will pay for human leukocyte antigen testing or histocompatibility locus antigen testing for use in bone marrow transplantation when necessary to establish a Member's bone marrow transplant donor suitability. This includes the costs of testing for A, B or DR antigens or any combination consistent with the rules and criteria established by the Massachusetts Department of Public Health.

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

Tufts Medicare Preferred Supplement Covered Services

Cleft lip or cleft palate treatment and services for children:
In accordance with applicable 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

Chapter 3: Benefit Schedule and Covered Services

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:

The Plan 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 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
- We do not cover the cost of services (including tuition-based programs) that offer educational, vocational, recreational or personal development activities, including, but not limited to: therapeutic schools, camps, wilderness or ranch programs, sports or performance enhancement programs, spas/resorts, leadership or behavioral coaching or Outward Bound. We will provide coverage for Medically Necessary Outpatient or intermediate behavioral health services provided by licensed behavioral health Providers while the Member is in a tuition-based program, subject to Plan rules, including network requirements or cost sharing.
- 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
- Any additional fee a Provider may charge as a condition of access or any amenities that access fee is represented to cover. Please consult with your Provider to determine if he or she charges such a fee.

The following footnote applies to all pages in chapter 3.

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

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 meet the Plan's or Tufts Health Plan Medicare Preferred's eligibility rules
  - 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 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 meet the Plan's or our eligibility rules, or 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 and you meet any qualifying event the Plan requires. To end your coverage, notify your Group at least 30 days before the date you want your coverage to end. You must also pay contributions for your coverage 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 your contributions for your coverage under this Tufts Health Plan Medicare Preferred Medicare Supplement Description of Benefits. You may continue this suspension of benefits and contributions for your coverage 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 contributions to your coverage 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 contributions to your coverage. 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 coverage under this Plan. 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 contributions to your coverage for the time period dating back to when you lost entitlement to Medicaid.

Once we have reinstated your overage under this Plan 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 contributions to your coverage 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:
Your coverage may be terminated 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 the Plan terminates your coverage for material misrepresentation, your coverage will end as of your Effective Date or a later date chosen by the Plan.

Payment of Claims:
The Plan will pay for all Covered Services you received between:

- Your Effective Date, and
- Your termination date, as chosen by the Plan. The Plan may retroactively terminate your coverage back to a date no earlier than your Effective Date.

The Plan may use any contributions to your coverage you paid for a period after your termination date to pay for any Covered Services you received after your termination date.

If the contributions you paid are is not enough to pay for that care, the Plan may, at its option:

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

If the contribution to coverage is more than is needed to pay for Covered Services you received after your termination date, the Plan will refund the excess to your Group.

TERMINATION OF THE GROUP CONTRACT

End of Tufts Health Plan Medicare Preferred's and Group's Relationship:
Coverage will terminate if the relationship between your Group and Tufts Health Plan Medicare Preferred ends for any reason, including

- Your Group's Contract with us terminates
- Your Group fails to pay Premiums on time
- We no longer offer this Medicare Supplement Plan, or
- We stop operating

Chapter 5: Member Satisfaction

Important Notes about Appeals and Grievances:

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

MEMBER SATISFACTION PROCESS

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

- Internal Inquiry
- Member Grievances Process
- Internal Member Appeals, and
- External Review by an Independent Review Organization designated by Tufts Health Plan

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 health care. Every effort will be made to resolve your concerns. If your concerns cannot be explained or resolved, or if you tell Customer Relations that you are not satisfied with the response you have received from Tufts Health Plan Medicare Preferred, we will notify you of any options you may have, including 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 accordance with the timelines outlined below.

Member Grievance Process:
A grievance is a formal complaint about actions taken by Tufts Health Plan Medicare Preferred 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, which will document your concern and forward it to an Appeals and Grievances Specialist 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 Tufts Health Plan Medicare Preferred 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 the "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.

Administrative Grievance Timeline:

- 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 Specialist coordinating the review of your grievance.
- If you file your grievance verbally, we will send you a written confirmation within forty-eight (48) hours. We will also include the name, address, and telephone number of the person coordinating the review.
- Tufts HP 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 may contact Customer Relations to file a clinical grievance; we recommend that you also discuss your concerns directly with your Provider.

We will notify you by mail, within five (5) business days after receiving your compliant informing you that your compliant has been received and provide you with the name, address, and telephone number of the Quality Management team member responsible for your clinical grievance. We will review your clinical 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.

Internal Member Appeals:
Requests for coverage that was denied as specifically excluded in this Description of Benefits or for coverage that was denied based on Medical Necessity determinations are reviewed as appeals through the Internal Appeals Process. You may designate in writing someone to act on your behalf. You have 180 days from the date you were notified of the denial of benefit coverage or claim payment to file your appeal.

You can submit a verbal appeal of a benefit coverage decision to Customer Relations, which will forward it to the Appeals and Grievances Department. You may also submit your appeal in person at the address listed at the beginning of this chapter. We encourage you to submit your appeal in writing to accurately reflect your concerns. Your letter should include:

- your complete name and address
- your ID number and suffix
- a detailed description of your request (including relevant dates, any applicable medical information, and Provider names), and
- copies of any supporting documentation

Within forty-eight (48) hours of the receipt of your verbal or written appeal, an Appeals and Grievances Specialist will send an acknowledgment of receipt to you, a request for authorization for the release of medical and treatment information.

Once you have signed and returned the authorization for the release of medical and treatment information to Tufts Health Plan Medicare Preferred, the Appeals and Grievances Specialist will document the date of receipt and coordinate the investigation of your appeal. In the event that you do not sign and return the authorization for the release of medical and treatment information to us within thirty (30) calendar days of the day you requested a review of your case, we may, in our discretion, issue a resolution of the appeal without reviewing some or all of your medical records.

The Tufts Health Plan Medicare Preferred Benefits Committee will review appeals concerning specific exclusions and payment disputes and make determinations. The Appeals Committee will make utilization management (Medical Necessity) decisions. If your appeal involves an adverse determination (Medical Necessity determination), it will be reviewed by a medical director and/or a practitioner in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review. The medical director and/or practitioner will not have previously reviewed your case.

You will have access to any medical information and records relevant to your appeal which are in the possession and control of Tufts Health Plan Medicare Preferred. The time limits of this process will be waived or extended by a mutual written agreement between you or your authorized representative and us.

The Appeals and Grievances Specialist will notify you in writing of our decision on your appeal, within no more than thirty (30) calendar days of the receipt of your appeal. The time limits may be waived or extended beyond the time allowed by law upon mutual verbal or written agreement between you or your authorized represented and Tufts Health Plan Medicare Preferred. The decision letter will include the specific reasons for the decision and references to the pertinent Plan provisions on which the decision is based.

Tufts Health Plan Medicare Preferred maintains records of each inquiry made by a Member or by that Member's authorized representative.

Expedited Appeals:
Tufts Health Plan Medicare Preferred recognizes that there are urgent circumstances that require a quicker turnaround than the thirty (30) calendar days allotted for the standard appeals process. We will expedite an appeal when your health may be in serious jeopardy or, in the opinion of your Physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal.

If your request meets the guidelines for an expedited appeal, it will be reviewed by a Medical Affairs Department Physician, Psychological Testing Reviewer, and/or practitioner in a same or similar specialty that typically manages the medical condition, procedure or treatment under review. The Medical Affairs Department Physician, Psychological Testing Reviewer, and/or practitioner will not have previously reviewed your case.

Your review will generally be conducted within 2 business days, but no later than 72 hours (whichever is less) after our receipt of the request.

If You Have Questions

If you have questions or need help submitting a grievance or an appeal, please call Customer Relations for assistance.

External Review
For appeals involving Medical Necessity determinations (adverse determinations) and benefit reviews where medical judgment was used, you or your authorized representative have the right to request an independent, external review of our Appeals decision. Appeals for coverage of services specifically excluded in your Description of Benefits and payment disputes are not eligible for external review. Should you choose to do so, send your request within four months of your receipt of written notice of the denial of your appeal to:

Tufts Health Plan Medicare Preferred
Attn: Appeals and Grievances Dept.
705 Mt. Auburn Street
P.O. Box 9193
Watertown, MA 02471-9193
(fax) 617-972-9509

In some cases, Members may have the right to an expedited external review. An expedited external review may be appropriate in urgent situations. An urgent situation is one in which your health may be in serious jeopardy, or, in the opinion of your Physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal.

If you request an external review, an independent organization will review the decision and provide you with a written determination. If this organization decides to overturn the appeal decision, the service or supply will be covered under the Plan within no more than 45 days after receipt of the request for standard external review. For expedited external review, the independent review organization will provide notice of the decision as expeditiously as possible, but not later than 72 hours after receipt of the request.

Chapter 6: Other Plan Provisions

SUBROGATION AND RIGHT OF RECOVERY

The provisions of this section apply to all current and former Plan participants. This Plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representatives of your estate, your decedents, minors, and incompetent or disabled persons. "You" and "your" includes anyone on whose behalf the Plan pays benefits. No Member hereunder may assign any rights that it may have to recover medical expenses from any person or entity responsible for causing your injury, illness, or condition without the prior express written consent of the Plan.

The Plan's right of subrogation or reimbursement, as set forth below, extend to al insurance coverage available to you due to an injury, illness, or condition for which the Plan has paid medical claims (including, but not limited to, any disability award or settlement, premises or homeowners' medical payments coverage, premises or homeowners' insurance coverage, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, no fault automobile coverage or any first party insurance coverage).

Your health plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds form any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interests are fully satisfied.

Subrogation

The right of subrogation means the Plan is entitled to pursue any claims that you may have in order to recover the benefits paid by the Plan. Immediately upon paying or providing any benefit under the plan, the plan shall be subrogated to (stand in the place of) all of your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The Plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

Reimbursement

If you receive any payment as a result of an injury, illness or condition, you agree to reimburse the Plan first from such payment for all amounts the Plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of your recovery. Benefit payments made under the Plan are conditioned upon your agreement to reimburse the Plan in full from any recovery you receive for your injury, illness, or condition.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any Provider), you agree that if you receive any payment as a result of an injury, illness or condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the Plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the Plan's subrogation and reimbursement interest are fully satisfied.

Lien Rights
Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of illness, injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any illness, injury, or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan, including, but not limited to, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the Plan.

Subrogation Agent
Tufts Health Plan administers subrogation recoveries for the Plan and may contract with a third party to administer subrogation recoveries for the Plan. In such case, that subcontractor will act as Tufts Health Plan's agent.

Assignment
In order to secure the Plan's recovery rights, you agree to assign to the Plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the Plan's subrogation and reimbursement claims. This assignment allows the Plan to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim
By accepting from the Plan, you acknowledge that the Plan's recovery rights are a first priority claim and are to be repaid to the Plan before you receive any recovery for your damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the Plan will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The Plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

Applicability to All Settlements and Judgments
The terms of this entire subrogation and right of recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical payments the Plan provided or purports to allocate any portion of such settlement or judgement to payments of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The Plan's claim will not be reduced due to your own negligence.

Cooperation

You agree to cooperate fully with the Plan's efforts to recover benefits paid. It is your duty to notify the Plan within 30 days of the date when any notice given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness, or condition. You and your agents agree to provide the Plan or its representatives notices of any recovery you or your agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, you and your agents agree to provide notice information requested by the Plan, Tufts Health Plan or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal injury protection. Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights or failure to reimburse the Plan from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until:

- the Plan is reimbursed in full
- termination of your health benefits, or
- the institution of court proceedings against you

You shall do nothing to prejudice the Plan's subrogation or recovery interest or prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the Plan's subrogation and reimbursement interest.

You acknowledge that the Plan has the right to conduct an investigation regarding the injury, illness, or condition to identify potential sources of recovery. The Plan reserves the right to notify all parties and his/her agents of lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the Plan has notified you that it has the right pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 et seq, to share your personal health information in exercising its subrogation and reimbursement rights.

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. The Plan will not provide coverage for any injury or illness for which it determines that the Member is entitled to benefits pursuant to any workers' compensation statute or equivalent employer liability, or indemnification law (whether or not the employer has obtained workers' compensation coverage as required by law).

If the Plan pays for the costs of health care services or medications for any work-related illness or injury, the Plan has 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 the Plan for any work-related illness or injury, please contact the Tufts Health Plan Liability to Recovery Department at 1-888-880-8699, x. 21098.

Future Benefits

If you fail to cooperate with and reimburse the Plan, the health Plan may deny any future benefit payments on any other claim made by your until the Plan is reimbursed in full. However, the amount of any Covered Services excluded under this section will not exceed the amount of your recovery.

Chapter 6: Other Plan Provisions

COORDINATION OF BENEFITS

Benefits under Other Plans:

You may have benefits under other plans for Hospital, medical, dental or other health care expenses.

The Plan has 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:

The Plan will coordinate benefits by determining:

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

The Plan 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 the Plan's COB program.

Right to recover overpayment:

The Plan 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. The Plan 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 Description of Benefits 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.

Chapter 6: Other Plan Provisions

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.

GROUP CONTRACT

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

Payments for Coverage:
The Plan under which you are covered is a self-funded Plan. This means that your Group is responsible for funding Covered Services for Members in accordance with the terms of the Plan. Under an administrative services agreement between your Group and Tufts Health Plan Medicare Preferred, we processes claims, disburses Plan funds and provides other Covered Services only when the Group has forwarded adequate funds to us to pay for Covered Services. This is the case even if your Group has charged you for some or all of the cost of coverage under the Plan. If your Group fails to provide adequate funds for claims payment, we have no responsibility to pay claims.

Changes to This Description of Benefits:
The Group may change this Plan and this Description of Benefits in accordance with the terms of the Plan. Revisions do not require the consent of Members. Notice of Tufts Health Plan Medicare Preferred's revisions will be sent to the Group and will include the effective date of the revision. The Group or Plan Administrator is responsible for notifying the Members of revisions. We are not responsible if the Group does not so notify Members. Any revisions will apply to all Members covered under the Plan on the effective date of the revision.

Notice:

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

Notice to us: Members should address all correspondence to:

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

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

When this Description of Benefits is Issued and Effective:
This Description of Benefits is issued and effective on your Effective Date on or after January 1, ~~2020~~2021 and supersedes all previous Description of Benefits.

Appendix A: Glossary of Terms

TERMS AND DEFINITIONS

This section defines the terms used in this Description of Benefits

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 Description of Benefits

- **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."

Anniversary Date

The date upon which the Group Contract first becomes effective and each successive annual renewal date.

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.

Appendix A: Glossary of Terms

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-certifiedbehavior 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.

Copayments
A copayment is the amount you must pay for certain Outpatient Covered Services before payments are made by the Plan. This amount may be charged to you for an office visit or per day, depending on the type of Covered Service. The amounts of your copayments for certain Covered Services are listed in the Benefit Schedule in Chapter 3.

Covered Services
The services and supplies for which the Plan will pay under this Description of Benefits 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.

Appendix A: Glossary of Terms

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.

Description of Benefits

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

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 the Plan's records you become a Member and are first eligible for Covered Services.

Appendix A: Glossary of Terms

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 layperson, 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.

Group
An employer or other legal entity with which Tufts Health Plan Medicare Preferred has an agreement to provide group coverage. An employer group subject to the Employee Retirement Income Security Act of 1974 (ERISA), as amended, is the ERISA plan sponsor. The group is your agent and is not our agent.

Appendix A: Glossary of Terms

Group Contract
The agreement between Tufts Health Plan Medicare Preferred and the Group under which we agree to provide certain administrative services and the Group agrees to pay us for those services.

The group contract includes this Description of Benefits and any documents.

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
Coverage for Member only.

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 Description of Benefits 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.

Appendix A: Glossary of Terms

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 is covered under the Plan and therefore entitled to all benefits in accordance with the Plan. 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-conventional 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)

Open Enrollment Period
The period each year when eligible persons are allowed to apply for coverage under the Plan.

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 employee health benefits plan established and maintained by the Group. This Description of Benefits only describes one health benefits option under the plan. For a description of other health benefit options under the plan, see your Plan Administrator.

Plan Administrator
The person(s) or entity designated by the Plan as the plan administrator or, if not so designated, the Group. Tufts Health Plan Medicare Preferred is not the plan administrator.

Premium
The total monthly cost of individual coverage which the Group pays to Tufts Health Plan Medicare Preferred.

Note: In some cases, we will bill you directly for this cost and you will pay us for this coverage.

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 Description of Benefits.

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 Medicare Preferred

Tufts Benefits Administrators, Inc., a Massachusetts corporation d/b/a Tufts Health Plan Medicare Preferred. Also referred to as: "we," "us," or "our."

Urgently needed 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 urgently needed 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 urgently needed care if it is rendered:

- After the urgent condition has been treated and stabilized
- And the Member is safe for transport