City of Newton
Medicare Complement Plan

Description of Benefits

This health plan, alone, **does not meet Minimum Creditable Coverage standards** and **will not satisfy** the individual mandate that you have health insurance. However, Medicare is a plan that meets MCC standards. **Because you have Medicare Part A and Part B, you meet MCC standards and will not be subject to a tax penalty.** Please see page i for additional information.

705 Mount Auburn Street
Watertown, MA 02472-1508

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum
Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship.
For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

This plan is not intended to provide comprehensive health care coverage and **does not meet Minimum Creditable Coverage standards**, even if it does include services that are not available in the insured's other health plans. However, Medicare is a plan that meets MCC standards. **Because you have Medicare Part A and Part B, you meet MCC standards and will not be subject to a tax penalty.**

If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.

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Plan Information

I. General Information

1. **Plan Name.** City of Newton Medicare Complement Plan.
2. **Plan Sponsor.** City of Newton

3. **Sponsor's ID Number.** 04-6001404

4. **Plan Numbers.** 11363-000 for Retirees in the Municipal System

5. **Plan Year.** July 1st – June 30th

6. **Plan Administrator and Agent for Service of Legal Process.** City of Newton

7. **Administration.** The City of Newton has contracted with *Tufts Health Plan* ("*Tufts HP*") for administrative services. *Tufts HP* performs certain services for Medicare Complement Plan, such as claims processing, but does not insure the Plan benefits or determine your eligibility under the Plan. This is the City's responsibility.

8. This Plan is not maintained pursuant to a collective bargaining agreement.

9. **Plan Fiscal Year.** The fiscal records of the Plan are kept on a Plan year basis ending on each June 30th.

10. **Loss of Benefits.** The City may terminate the Plan at any time, or may modify, amend or change the provisions, terms and conditions of the Plan consistent with Massachusetts General Law Chapter 32B, or any other applicable state or federal law.

11. **Plan Effective Date.** July 1, 1994

12. **Member ID Number.** The member's ID number is his or her Medicare number.

13. **Description of Benefits Effective Date.** July 1, 2021

II. Member's Contribution to Benefits

Benefits for Members:
The Member is required to contribute to the cost of benefits as determined from time to time by the Plan Sponsor.

III. Enrollment

Eligibility: In order to be eligible for coverage under the Plan, the Member must be qualified under Massachusetts General Law Chapter 32B, as accepted by the City of Newton, and have Medicare Parts A and B.

Tufts Health Plan Address and Telephone Directory

TUFTS HEALTH PLAN
705 Mount Auburn Street
Watertown, Massachusetts 02472-1508

Member Services Hours: Monday through Thursday 8:00 am to 7:00 pm EST
Friday 8:00 am to 5:00 pm EST

IMPORTANT PHONE NUMBERS:

Emergency Care

If you have an urgent medical need, 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.

Liability Recovery

Call the Liability and Recovery Department at 1-888-880-8699, ext. 21098 for questions about coordination of benefits. For example, call the Liability and Recovery Department if you have any questions about how *Tufts Health Plan* (*Tufts HP*) coordinates coverage with Medicare and other health care coverage that you may have. The Liability and Recovery Department is available from 8:00 a.m. – 5:00 p.m. Monday through Friday.

For questions related to subrogation, call a Member Representative at 1-800-462-0224. If you are uncertain which department can best address your questions, call Member Services.

Medicare

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

Member Services Department

Call for general questions, assistance in choosing a physician, benefit questions, and information regarding eligibility for enrollment and billing. 1-800-462-0224. For help finding a *Tufts HP Provider*, call Member Services and follow the appropriate prompts. Our Member Services team can help you find a *Tufts HP Provider* who is appropriate for your age, condition and type of treatment.

Behavioral Health and Substance Use Disorder Services

If you need assistance locating a *Provider* or finding information about your behavioral/substance use disorder benefits, please contact the *Tufts Health Plan* Behavioral Health department at 1-800-208-9565.

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

Telecommunications Device for the Deaf (TDD)
If you have access to a TDD phone, call 711. You will reach the *Tufts HP* Member Services Department.

Massachusetts Relay (MassRelay)
711

Fraud, Waste and Abuse
You may have concerns about being billed for services you never received, or that your insurance information has been stolen or used by someone else. To report potential health care fraud or abuse, or if you have questions, please call Member Services, 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

Appeals and Grievances Department
If you need to call *Tufts HP* about a concern or appeal, contact Member Services. To submit your Appeal or Grievance in writing, send your letter to the address below. Or you may fax it to us at 617-972-9509. You may also submit your appeal or grievance in person at this address:

Tufts Health Plan
Attn: Appeals and Grievances Department
705 Mount Auburn Street
P.O. Box 9193
Watertown, MA 02472-9193
Fax: 617-972-9193

Website
For more information about *Tufts Health Plan* and to learn more about the self-service options that are available to you, please see the *Tufts Health Plan* website.

Translating services for more than 200 languages

Interpreter and translator services related to administrative procedures are available to assist *Members* upon request.

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.

German Um eine kostenlose deutsche Übersetzung zu erhalten, rufen Sie bitte die Telefonnummer auf Ihrer Ausweiskarte an.

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

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

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

Japanese 日本語の無料翻訳については ID カードに書いてある番号に電話してください。

Khmer (Cambodian) សម្រាប់សេវាបកប្រែដោយឥតគិតថ្លៃជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខដែលមាននៅលើប័ណ្ណសម្គាល់សមាជិករបស់អ្នក។

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

Laotian ສໍາລັບການແປພາສາບ່ັນພາສາລາວທ່ີບ່ໍໄດ້ເສຍຄ່າໃຊ້ຈ່າຍ, ໃຫ້ໂທຫາເບ ີ່ ທ ່ີ ຢ ູ່ ເ ທ ິ ງ ບ ັ ດ ປ ະ ຈ ໍ າ ຕ ົ ວ ຂ ອ ງ ທ ່ ານ.

Navajo Doo bą́ąh ilíní da Diné k'ehjí álnéehgo, hodiilnih béésh bee haní'é bee néé ho'dílzingo nantinígíí bikáá'.

Persian. برای ترجمه رایگا فارسی به شماره تلفن مندرج در کارت شناسائی تان زنگ بزنید

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.

Telecommunications Device for the Deaf

711

MassRelay

MassRelay is a service designed for people who live or work in Massachusetts and use a text based device for phone conversations or want to communicate with someone who does:

711

Chapter 1
How The *Plan* Works

Overview

Introduction

Welcome to the Medicare Complement *Plan* administered by *Tufts Health Plan* ("*Tufts HP*"). We are pleased you have chosen *Tufts HP*. We look forward to working with you to help you meet your health care needs. Your satisfaction with *Tufts Health Plan* is important to us. If at any time you have questions, please call either a Member Representative at 1-800-462-0224 or the Liability and Recovery Department at 1-888-880-8699, ext. 21098 and we will be happy to help you.

The Medicare Complement Plan, in conjunction with Medicare, offers a comprehensive package of medical benefits. Medicare Complement *Plan* is designed to add to 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 Medicare Complement Plan, coverage is provided for certain services which are not covered under Medicare. Those services include:

- preventive care, including routine health exams; and
- prescription drug coverage.

Selection of a primary care physician is not required for Medicare Complement Plan; however, it is strongly recommended that you utilize one physician for the coordination of your care.

Members do not need to get referrals to receive benefits under this *Plan*. Benefits will be paid as described in Chapter 3.

It is important for you to present your Medicare card as well as your Medicare Complement *Plan* identification card to your health *Provider* (physician, hospital, etc.) when you receive services.

Eligibility for Benefits under Medicare Complement Plan

Tufts HP covers only the services and supplies described as *Covered Services* in Chapter 3. There are no pre-existing condition limitations under this *Plan*. You are eligible to use your benefits as of your *Effective Date*.

Description of Benefits

This book, called your *Description of Benefits*, will help you find answers to your questions about *Tufts Health Plan* benefits. *Tufts HP* certifies that you have the right to services and supplies described in this *Description of Benefits* which are *Medically Necessary*.

Medicare provides primary coverage for *Covered Services* and receives claims first. Medicare Complement Plan provides secondary coverage and receives claims for payments after Medicare has made its coverage determination. Medicare sets a fee schedule for *Covered Services* and pays according to its established fees, minus *Deductibles* and/or *Coinsurance.* Medicare Complement Plan pays the *Deductible* and/or *Coinsurance* for most Medicare *Covered Services* as described in this booklet. Neither Medicare nor Medicare Complement Plan will pay charges that are higher than the Medicare Approved Amount (which is based on the Medicare fee schedule).

Coverage 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 Health Care Financing Administration may be obtained:

- by contacting your local Social Security office; or
- via the internet on the official Medicare website at **www.medicare.gov**.

In addition, please refer to your Medicare Handbook for any questions pertaining to the Medicare portion of your health care under Medicare Complement Plan.

Please note that words with special meanings appear as italicized words in this *Description of Benefits*. Those words are defined in the Glossary in Appendix A.

Calls to Member Services

The *Tufts HP* Member Services Department is committed to excellent service.

All calls are recorded for training and quality purposes.

How the *Plan* Works

Primary Care Physicians

Selection of a primary care physician is not required for Medicare Complement Plan. However, it is strongly recommended that you utilize one physician for the coordination of your care.

Medically Necessary services and supplies

The *Plan* will pay for *Covered Services* and supplies when they are *Medically Necessary*.

Important: The *Plan* will not pay for services or supplies which are not *Covered Services*.

Financial Arrangements between *Tufts HP* and *Tufts HP Providers*

Methods of payment to *Tufts HP Providers*

Tufts HP's goal in compensation of *Providers* is to encourage preventive care and active management of illnesses. *Tufts HP* strives to be sure that the financial reimbursement system we use encourages appropriate access to care and rewards *Providers* for providing high quality care to our *Members*. *Tufts HP* uses a variety of mutually agreed upon methods to compensate *Tufts HP Providers*.

The *Tufts HP Directory of Health Care Providers* indicates the method of payment for each *Provider*. Regardless of the method of payment, *Tufts HP* expects all participating *Providers* to use sound medical judgment when providing care and when determining whether a referral for specialty care is appropriate. This approach encourages the provision of *Medically Necessary* care and reduces the number of unnecessary medical tests and procedures which can be both harmful and costly to *Members*.

Tufts HP oversees the provision of care through its Quality of Health Care Program. You should feel free to discuss with your *Provider* specific questions about how he or she is paid.

Member Identification Card

Introduction

Tufts HP gives each Member a Member identification card (Member ID card).

Reporting errors

When you receive your Member ID card, check it carefully. If any information is wrong, call a Member Representative at 1-800-462-0224.

Using your card

Your Member ID card is important because it identifies your health care plan. Please remember to:

- carry your Member ID card at all times;
- have your Member ID card with you for medical, hospital and other appointments; and
- show your Member ID card to any *Provider* before you receive health care.

Identifying yourself as a *Tufts HP Member*

Your Member ID card is important because it identifies your health care plan. Please:

- 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.

When you receive services, you must tell the office staff that you are a *Tufts HP Member*.

IMPORTANT NOTE: If you do not identify yourself as a *Tufts HP Member*, then
- the *Plan* may not pay for the services provided, and
- you would be responsible for the costs.

What to Do in an *Emergency*

Guidelines for receiving 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.
- If you receive *Outpatient* Emergency care at an emergency facility, you or someone acting for you should call *Tufts HP* within 48 hours after receiving care. You are encouraged to contact your primary care physician so he or she can provide or arrange for any follow-up care that you may need.

Important Note:

For information about obtaining Emergency Care and Urgent Care services outside of the United States, please see “Foreign Travel” in Chapter 3.

Chapter 2

Eligibility

Eligibility

Eligibility rule

You are eligible as a *Member* only if you meet all of the following criteria, subject to federal law:

- You are eligible for and 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.
- You are in the class of eligible retirees established by the Plan.

Proof of eligibility

Tufts HP or the City may ask you for proof of your eligibility or continuing eligibility. You must provide proof when asked. This may include proof of:
- residence, and
- Medicare Part A and B enrollment.

The City is not required to enroll any applicant who refuses to provide the requested information.

Enrollment

Enrollment is always subject to the City's acceptance of the member application. Acceptance will be based upon the satisfaction of all the City's eligibility requirements.

Initial Application

In order to enroll, the applicant must submit a completed member application to the City and must list the *Subscriber* as well as any other health insurance which covers the applicant. Upon the Plan's acceptance of the member application, coverage will be effective as described below. The *Effective Date* of coverage will appear on the Member's ID card.

Eligibilty, continued

Member applications

When applicants sign an application form they:

- represent that all information provided is true and complete to the best of their knowledge and belief;
- agree to accept the terms and conditions of coverage under the *Plan*, including any future amendments;
- assign to the *Plan* any legal right that they may have to recover the cost of services paid, or to be paid, by the *Plan* for an illness or injury caused by someone else; and
- are put on notice that they can be liable to the *Plan* for the cost of benefits, reasonable attorneys' fees and legal costs if they fraudulently obtain a health care or payment from the *Plan*.

Effective Date* for *Subscribers

If the *Subscriber* submits a member application before he or she is eligible, or within 31 days after becoming eligible, coverage will be effective on the date of his or her eligibility.

Member Identification cards

Tufts HP gives each *Member* a member identification card (Member ID card). Persons covered under this *Plan* have single coverage.

When you receive your Member ID card, check it carefully. If any information is wrong, call a Member Representative.

Continuing Eligibility

Maintaining accurate information about *Members* will help the *Plan*, *Tufts HP*, and *Members* ensure continuing eligibility for *Covered Services*. It is the Member's responsibility to promptly inform *Tufts HP*'s Member Services Department or the City, in writing, of all changes that affect his or her eligibility. Forms to report these changes are available from the City. Examples of such changes include changes in marital status or death; any address changes; and changes in Medicare eligibility**.**

Chapter 3

Covered Services

When health care services are *Covered Services*

Health care services and supplies are *Covered Services* only if they are:

- listed as *Covered Services* in this chapter, or covered under Parts A and B of Original Medicare. Such Medicare-covered services are covered under this *Plan*, even if they are not specifically listed in this *Description of Benefits*. The *Plan* pays the charges for the Part A or B *Deductibles* and/or *Coinsurance* that Medicare requires you to pay for those services;
- *Medically Necessary*, as determined by *Tufts HP* and Medicare;
- consistent with applicable law;
- consistent with *Tufts Health Plan*'s Medical Necessity Coverage guidelines in effect at the time the services or supplies are provided. This information is available to you on our website or by calling Member Services; and
- provided to treat an injury, illness or pregnancy, except for preventive care.

IMPORTANT NOTE:

The *Plan* will pay:

- the *Deductibles* and *Coinsurance* for Medicare-eligible services; and
- the applicable benefit amount for all other *Covered Services* up to the *Reasonable Charge*.

Please see the *Covered Services* tables in Chapter 3 to determine whether you may be required to pay a *Copayment* to the *Plan* for certain *Covered Services*.

Costs in Excess of the Medicare Approved Amount

The *Member* is responsible for paying any charges in excess of the Medicare Approved Amount for Medicare Part B Services. In most cases, Medicare has contracts with doctors and suppliers who agree to accept the amount approved by Medicare as total payment for *Covered Services*. These Medicare participating doctors and suppliers have agreed to accept assignment on all Medicare Part B claims. If your doctor or supplier is not Medicare participating and does not accept assignment, you must pay the doctor or supplier directly and seek reimbursement from Medicare and the Plan for the amounts they would have paid. Please refer to your Medicare Handbook for a complete explanation.

***Covered Services* table**

Health care services and supplies only qualify as *Covered Services* if they meet the requirements shown above for "When health care services are *Covered Services*". The following table (beginning on page 16) describes those services that qualify as *Covered Services*.

***Covered Services*, continued**

***Covered Services* table (Part A)** The following table describes the *Covered Services* available to you under Medicare Part A of Original Medicare and the Medicare Complement Plan.

Part A Benefits			
Benefit	**Medicare Pays...**	**The *Plan* Pays…**	**You Pay…**
Hospital *Inpatient* Care provided at a Medicare-certified general hospital: • Semiprivate room (private room if *Medically Necessary*); • Regular nursing services (private duty nursing services are not covered); • *Inpatient* Provider services; • Surgery. Note: The following services apply in connection with a mastectomy: (1) reconstruction of the breast affected by the mastectomy; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prostheses* and treatment of physical complications of all stages of mastectomy (including lymphedema). *Prosthetic devices are covered as described under "*Durable Medical Equipment*". Removal of breast implants is covered when any of the following conditions exist: (1) the implant was placed post-mastectomy; or (2) there is documented evidence of auto-immune disease. Note: No Coverage is provided for the removal of intact or ruptured saline breast implants or intact silicone breast implants except as specified above.	Days 1-60 in *Benefit Period*: All *Covered Services*, except the Part A *Deductible*.	The Part A *Deductible*.	Nothing.
	Days 61-90 in *Benefit Period*: All covered costs, except the hospital *Coinsurance*.	The hospital *Coinsurance*.	Nothing.
	Reserve Days: All *Covered Services*, except the *Reserve Day Coinsurance*, for 60 extra lifetime *Reserve Days*.	The *Reserve Day Coinsurance,* for 60 extra lifetime *Reserve Days*. After the 60 extra lifetime *Reserve Days* are exhausted, the *Plan* pays all *Covered Services* up to a combined total of 365 days per *Benefit Period*.	Nothing for each of the 60 extra lifetime *Reserve Days*. Also, you pay nothing for the first 365 days in a *Benefit Period* after the *Reserve Days* are exhausted. You pay all charges after 365 days in a *Benefit Period*.

Part A Benefits (continued)			
Benefit	**Medicare Pays...**	**The *Plan* Pays…**	**You Pay…**
Hospital *Inpatient* Care provided at a Medicare-certified general hospital (continued): • Use of operating/recovery rooms; • Meals, including special diets; • Drugs and medications furnished by the hospital during your stay; • Laboratory tests; and X-rays and other radiological services; • Medical supplies, such as casts, surgical dressings, and splints; • Cost of special care units, including intensive care and coronary care units; • Rehabilitation services, such as physical therapy, occupational therapy, speech pathology services, nuclear cardiology, and kidney dialysis; • Maternity care services; • Psychiatric and/or psychologist services in a general hospital; • Substance use disorder detoxification and rehabilitation services*; and • All other *Medically Necessary* services and supplies.	See page 16 above for the amounts paid for these *Covered Services* by Medicare, by you, and by *Tufts Health Plan*. *If *Inpatient* substance abuse detoxification and rehabilitation services are provided in conjunction with a treatment of a Mental Disorder, coverage is the same as for "Hospital *Inpatient* Care" at a general hospital (as shown on page 16).		

Part A Benefits (continued)			
Benefit	**Medicare Pays...**	**The *Plan* Pays…**	**You Pay…**
Inpatient blood services The following, provided as part of a covered *Inpatient* stay in a hospital or *Skilled* Nursing Facility: • Whole blood; • Packed red blood cells; • Blood components; and • The cost of blood processing and administration.	All *Covered Services*, **except** for the annual blood *Deductible*. This *Deductible* is for the first 3 pints of unreplaced blood during a calendar year.	The cost of the annual blood *Deductible*.	Nothing.

Part A Benefits (continued)			
Benefit	**Medicare Pays...**	**The *Plan* Pays…**	**You Pay…**
<u>*Skilled* Nursing Facility (SNF) care</u> *Skilled* nursing and rehabilitation services performed by or provided under the supervision of licensed nursing personnel: • Semi-private room; • Nursing services; • Meals, including special diets; • Physical, occupational, and speech therapy; • Drugs and medications furnished by the *Skilled* nursing facility during your stay; • Medical supplies, such as casts, surgical dressings, and splints; • Diagnostic services, such as x-rays and laboratory services. <u>Note</u>: *Custodial care* is not covered by either Medicare or the *Plan*.	<u>Days 1 to 20 in a *Benefit Period*</u>: All *Covered Services*.	Nothing.	Nothing.
	<u>Days 21 to 100 in a *Benefit Period*</u>: All *Covered Services*, except for the SNF *Coinsurance*.	The SNF *Coinsurance*.	Nothing.
	<u>Days 100+ in a *Benefit Period*</u>: Nothing	Nothing.	All charges after a 100-day SNF stay.

Part A Benefits (continued)			
Benefit	**Medicare Pays...**	**The *Plan* Pays…**	**You Pay…**

Home Health Care Services:
• Services provided to a homebound* *Member* in his/her home by a home health agency:
  • Part-time or Skilled nursing care;
  • Physical therapy; and
  • Speech therapy.
• If you need *Skilled* nursing care, physical therapy, or speech therapy, Medicare may also pay for:
  • Occupational therapy;
  • Part-time or intermittent services of a home health aide;
  • Medical social services; and
  • Medical supplies and *Durable Medical Equipment* provided by the Home Health Agency.
Note: *Custodial Care* is not covered by either the *Plan* or Medicare.
	For nutritional counseling, physician home visits, and inhalation therapy:
	Nothing.
		All *Medically Necessary* charges.	Nothing.

	For *Durable Medical Equipment*: 80% of the Medicare-approved amount.	20% of the Medicare-approved amount.	Nothing.
	For All other Covered Home Health Care Services: All Charges.	Nothing.	Nothing.

Sleep studies performed in the home are not covered under this "Home Health Care" benefit. Instead, these sleep studies are covered as described under "Diagnostic testing" earlier in this chapter.

*Homebound: To be considered homebound, you do not have to be bedridden. However, your condition should be such that there exists a normal inability to leave the home and, consequently, leaving the home would require a considerable and taxing effort. If you leave the home, you may be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or to receive medical treatment.

Part A Benefits (continued)			
Benefit	**Medicare Pays...**	**The *Plan* Pays…**	**You Pay…**
Inpatient Services at a chronic care or Rehabilitation Facility Acute *Inpatient* rehabilitation services provided in an *Inpatient* Rehabilitation Facility.	Days 1-60 in a *Benefit Period*: All *Covered Services*, except Part A *Deductible*.	The Part A *Deductible*.	Nothing.
	Days 61-90 in a *Benefit Period*: All *Covered Services*, except hospital *Coinsurance*.	The hospital *Coinsurance*.	Nothing.
	Reserve Days: All *Covered Services*, except *Reserve Day Coinsurance* for 60 extra lifetime *Reserve Days*.	The *Reserve Day Coinsurance*, for 60 extra lifetime *Reserve Days*.	Nothing.

Part A Benefits (continued)			
Benefit	**Medicare Pays...**	**The *Plan* Pays…**	**You Pay…**
Inpatient Services at a chronic care or Rehabilitation Facility (continued from previous page)	Additional Days: Nothing.	You could incur *Inpatient* days that Medicare pays for either during a covered *Benefit Period* or as *Reserve Days* or excludes because they occur (1) outside of covered *Benefit Period*(s) or (2) after you have exhausted your 60 lifetime *Reserve Days*. If the total number of these days (covered & excluded combined) is less than 100 in a calendar year, the *Plan* will cover any additional days in that year to bring the total to 100 days. The *Plan* will pay all charges for these additional days.	As described in the "The *Plan* Pays" column on this page, you pay nothing for any of the Additional Days that the *Plan* covers in a calendar year. You pay all charges for any Additional Days not covered by the *Plan.*

Part A Benefits (continued)			
Benefit	**Medicare Pays...**	**The *Plan* Pays…**	**You Pay…**
<u>Hospice care for terminally ill *Member*s with a life expectancy of 6 months or less:</u> • Home care provided by a hospice program, either a private organization or a public agency, with an emphasis on providing comfort and relief from pain, including: physician services, nursing care, medical appliances and supplies, and physical therapy, occupational therapy and speech therapy services; • Services not ordinarily covered by Medicare, including homemaker services, counseling, and certain prescription drugs * provided for pain or symptom relief; and • *Inpatient* respite care intended to give temporary relief to the person or persons who regularly assist with home care. Covered up to a maximum of 5 consecutive days. *Medicare patients can be charged a *Copayment* for these prescription drugs and *Coinsurance* for *Inpatient* respite care.	<u>For each day of Medicare-approved *Inpatient* respite care (maximum of 5 consecutive days) allowed by Medicare:</u> All *Covered Services*, except the Medicare *Coinsurance*.	The Medicare *Coinsurance*.	Nothing.
	<u>For each covered prescription drug:</u> All *Covered Services*, except the Medicare *Copayment*.	Nothing.	The Medicare *Copayment*.
	<u>For all other *Covered Services*:</u> All *Covered Services*.	Nothing.	Nothing.

Covered Services table (Part B)

The following table describes the *Covered Services* available to you under Medicare Part B of Original Medicare and the Medicare Complement Plan.

Note: Certain Part B preventive care services are listed in the table below with Medicare paying 100% of Medicare-approved amount. Please note that Medicare may charge you the Part B *Deductible* or *Coinsurance* when these services are provided in conjunction with an office visit.

Part B Benefits			
Benefit	**Medicare Pays...**	**The *Plan* Pays…**	**You Pay…**

Preventive care services
• A baseline mammogram (for women between the ages of 35 and 40).
• Annual mammography screenings (for women age 40 and over).
• Pap smear, including pelvic exam (once every 3 years), or annual coverage for women:
  • at high risk for cervical or vaginal cancer, or
  • of child bearing age who have had a pap smear during the preceding 3 years indicating the presence of cervical or vaginal cancer or other abnormality.
	For baseline and annual mammography screenings:
	100%of the Medicare-approved amount.
		Nothing.	Nothing.

	For Pap Smears (clinical laboratory charge): 100% of the Medicare approved amount.	All charges for annual PAP smear not otherwise covered by Medicare.	Nothing.
	80% of the Medicare-approved amount for doctor services and all other exams.	20% of the Medicare-approved amount for doctor services and all other exams.	Nothing.

Part B Benefits (continued)			
Benefit	**Medicare Pays**	**The *Plan* Pays…**	**You Pay…**
Preventive care services (continued) Colorectal cancer screening exam, including: • Guaiac-based fecal occult blood test (gFOBT) or Fecal immunochemical test (FIT), flexible sigmoidoscopy, colonoscopy, and DNA based colorectal screening; flexible sigmoidoscopy once every four years for persons age 50 and over; • colonoscopy once every two years for persons at high risk for 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; and • DNA based colorectal screening every three years.	For the fecal occult blood test: 100% of the Medicare approved amount.	Nothing.	Nothing.
	For all other tests: 100% of the Medicare-approved amount.	Nothing.	Nothing.

Part B Benefits (continued)			
Benefit	**Medicare Pays**	**The *Plan* Pays…**	**You Pay…**
Barium enema – Doctor can substitute for sigmoidoscopy or colonoscopy.	80% of the Medicare-approved amount, except for the annual Part B *Deductible*.	The annual Part B *Deductible* and 20% of the Medicare-approved amount.	Nothing.
Prostate cancer screening (for men age 50 and over) • digital rectal exam, and • PSA test.	For digital rectal exam: 80% of the Medicare-approved amount, except for the annual Part B *Deductible*.	The annual Part B *Deductible* and 20% of the Medicare-approved amount.	Nothing.
	For PSA test: 100% of the Medicare-approved amount,	Nothing.	Nothing.

Part B Benefits (continued)			
Benefit	**Medicare pays...**	**The *Plan* Pays…**	**You Pay…**
Preventive care services (continued) Vaccinations covered under Medicare Part B*: • Flu shot once per year • Pneumonia shot, generally, one per lifetime • Hepatitis B shot for people at medium to high risk (check with your doctor) * Other vaccines are covered under Medicare Part B **only** when directly related to the treatment of an injury or direct exposure to a disease or condition (for example, a tetanus shot, if you step on a rusty nail or a rabies shot if you are bitten by an animal). Otherwise, commercially available vaccines (like the shingles vaccine) are covered under the Outpatient Prescription Drug when medically necessary to prevent illness.	100% of the Medicare-approved amount.	Nothing.	Nothing. Nothing.

Part B Benefits (continued)			
Benefit	**Medicare pays...**	**The *Plan* Pays…**	**You Pay…**
Preventive care services (continued) Alcohol Screening and counseling to reduce alcohol misuse 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.	Medicare benefits in full: Once Medicare provides coverage, Tufts Health 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.	Nothing.	Nothing.
For more information about these programs, call the Tufts Health Plan Behavioral Health Department at 1-800-208-9565			
Abdominal aortic aneurysm screening 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.	Medicare benefits in full: Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for a one-time screening ultrasound for people at risk.	Nothing.	Nothing.
Depression Screening 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.	Medicare benefits for Depression screening in full for annual Depression screening.	Nothing.	Nothing.

Part B Benefits (continued)			
Benefit	**Medicare pays...**	**The *Plan* Pays…**	**You Pay…**
<u>Preventive care services (continued)</u> <u>HIV screenings</u> 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	Medicare benefits in full for HIV screening.	Nothing.	Nothing.

Part B Benefits (continued)			
Benefit	**Medicare pays...**	**The *Plan* Pays…**	**You Pay…**
• One-time physical exam within 12 months after Part B coverage begins. • Annual wellness exam (applies in years following initial one-time Part B physical exam).	100% of the Medicare-approved amount.	Nothing.	Nothing.
Bone mass measurement for *Member*s at risk for losing bone mass. **Note:** Covered once every 24 months.	For bone mass measurement: 100% of the Medicare-approved amount.	Nothing.	Nothing.
Diabetes self-management training.	80% of the Medicare-approved amount, except for the annual Part B *Deductible*.	The annual Part B *Deductible* and 20% of the Medicare-approved amount.	Nothing.
Medicare-approved smoking and tobacco use cessation counseling.	100% of the Medicare-approved amount.	Nothing	Nothing.
Medical nutrition therapy.	100% of the Medicare-approved amount.	Nothing.	Nothing.

<table>
<tr><th colspan="4">Part B Benefits (continued)</th></tr>
<tr><th>Benefit</th><th>Medicare Pays...</th><th>The Plan Pays…</th><th>You Pay…</th></tr>
<tr><td><u>Emergency room care:</u>
Medically Necessary Emergency services obtained in a hospital Emergency room.</td><td>80% of Medicare-approved Covered Services, except for the annual Part B Deductible.</td><td>The annual Part B Deductible and 20% Coinsurance.</td><td>Nothing.</td></tr>
<tr><td colspan="4">Once Medicare approves the coverage, the Plan provides coverage up to the Allowed Charge for Medicare-approved Emergency Room and Urgent Care services within the United States.

<u>Note</u>: 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.</td></tr>
<tr><td rowspan="2"><u>Outpatient services:</u>
• Office visits;
• Consultation by specialists, including obstetrical and gynecological services;
• Allergy testing and treatment;
• Outpatient physical, occupational, and speech therapy (for diagnosis and treatment of speech, hearing, and language disorders);
• Medical services and surgery;

(continued on next page)</td><td>80% of Covered Services, except for the annual Part B Deductible.</td><td>The annual Part B Deductible and 20% Coinsurance, minus a $10 Copayment per visit.</td><td rowspan="2">A $10 Copayment per visit.</td></tr>
<tr><td colspan="2"><u>Notes:</u>
• Emergency room Copayment is waived if you are admitted as an Inpatient.
• An Emergency room Copayment is waived if you register in an Emergency room but leave the facility without receiving care.
• Observation services will not take an Emergency room Copayment.</td></tr>
</table>

Part B Benefits (continued)			
Benefit	**Medicare Pays...**	**The *Plan* Pays…**	**You Pay…**
Outpatient services - continued: • Immunizations; • Diagnostic imaging services, including general imaging (such as x-rays and ultrasounds) and MRI/MRA, CT/CTA, PET, and nuclear cardiology; • Diagnostic laboratory services including, but not limited to, glycosylated hemoglobin (HbA1c) and urinary protein/microalbumin and lipid profiles; • Inhalation and other home health therapies; • Radiation therapy • Manipulation of the spine to correct a dislocation that can be shown by an x-ray. *(continued on next page)*	Diagnostic laboratory services: All *Covered Services*.	Nothing.	Nothing.
	All other *Outpatient* services listed on this page: 80% of Medicare-approved *Covered Services*, except for the annual Part B *Deductible*.	The annual Part B *Deductible* and 20% *Coinsurance*, minus a $10 *Copayment* per visit.	A $10 *Copayment* per visit. .

Part B Benefits (continued)			
Benefit	**Medicare Pays...**	**The *Plan* Pays…**	**You Pay…**
Outpatient services – continued: Podiatric services, when Medicare-approved and provided by a doctor of podiatry or surgical chiropody. * *Note: Routine foot care is not covered.	80% of *Covered Services*, except for the annual Part B *Deductible*.	The annual Part B *Deductible* and 20% *Coinsurance*, minus a $10 *Copayment* per visit.	A $10 *Copayment* per visit.
The following dental services: • Trauma care, reduction of swelling, and pain relief, for damage to sound and natural teeth; • Reduction of dislocations or fractures of the jaw.	80% of *Covered Services*, except for the annual Part B *Deductible*.	The annual Part B *Deductible* and 20% *Coinsurance*, minus a $10 *Copayment* per visit.	A $10 *Copayment* per visit.
Inpatient or ambulatory surgical services for a non-dental medical condition that requires you to be in a hospital when you receive dental care.	80% of *Covered Services*, except for the annual Part B *Deductible*.	The annual Part B *Deductible* and 20% *Coinsurance* per visit.	Nothing.

Part B Benefits (continued)			
Benefit	**Medicare Pays...**	**The *Plan* Pays…**	**You Pay…**

<u>Physical therapy, occupational therapy, and speech pathology services, when provided:</u>
 	
• in the following facilities:
  • clinic,
  • hospital,
  • rehabilitation facility, or
  • SNF;
• by a home health agency; or
• by an independent practicing therapist.
	80% of *Covered Services*, except for the annual Part B *Deductible*.	The annual Part B *Deductible* and 20% *Coinsurance* minus a $10 *Copayment* per visit.	A $10 *Copayment* per visit.

<u>*Outpatient* blood services</u> • Whole blood; • Packed red blood cells; • Blood components; and • The cost of blood processing and administration.	80% of *Covered Services*, except for the annual Blood *Deductible* and the annual Part B *Deductible*.	The cost of the annual Blood *Deductible*, the annual Part B *Deductible*, and 20% *Coinsurance*.	Nothing.

***Covered Services*, continued**

<table>
<tr><th colspan="4">Part B Benefits (continued)</th></tr>
<tr><th>Benefit</th><th>Medicare Pays...</th><th>The Plan Pays…</th><th>You Pay…</th></tr>
<tr><td rowspan="2">Ambulance services:
Transportation between:
• your home and a hospital;
• your home and a SNF; or
• a hospital and a SNF;
if:
• the ambulance and personnel meet Medicare requirements; and
• transportation in any other vehicle could endanger your health.</td><td>80% of Covered Services, except for the annual Part B Deductible.</td><td>The annual Part B Deductible and 20% Coinsurance.</td><td rowspan="2">Nothing.</td></tr>
<tr><td colspan="2">Important Note: If you are treated by Emergency Medical Technicians (EMTs) or other ambulance staff, but refuse to be transported to the hospital or other medical facility, you will be responsible for the costs of this treatment.</td></tr>
<tr><td rowspan="2">Durable Medical Equipment (DME):
Includes coverage for 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.
Note: Includes breast prostheses (including surgical brassiere after a mastectomy).</td><td>80% of Covered Services, except for the annual Part B Deductible.</td><td>The annual Part B Deductible and 20% Coinsurance.</td><td rowspan="2">Nothing.</td></tr>
<tr><td colspan="2">In order to be eligible for coverage, the equipment must also be the most appropriate available supply or level of service for the Member in question considering potential benefits and harms to that individual.
.</td></tr>
</table>

Part B Benefits (continued)			
Benefit	**Medicare Pays...**	**The *Plan* Pays…**	**You Pay…**
Medical supplies: Examples of *Covered Services* are dressings, splints, and casts.	80% of *Covered Services*, except for the annual Part B *Deductible*.	The annual Part B *Deductible* and 20% *Coinsurance*.	Nothing.
The following equipment for use in diabetes monitoring by Medicare beneficiaries with diabetes: Blood glucose monitors, including voice synthesizers for blood glucose monitors for use by the legally blind; visual magnifying aids; therapeutic/molded shoes and shoe inserts for a *Member* with severe diabetic foot disorder; blood glucose monitoring strips, lancets, and self-management.	80% of Medicare-approved *Covered Services*, except for the annual Part B *Deductible*.	The annual Part B *Deductible* and 20% of the Medicare-approved amount.	Nothing.
		Note: *Tufts HP* also pays for the following *Covered Services* to the extent such services and supplies are not covered by Medicare: • Urine and ketone monitoring strips. See the Prescription Drug Benefit later in this chapter for more information. • Diabetes self-management. See "Diabetes self-management training and educational services" on page 16 for more information.	
Comprehensive Outpatient Rehabilitation Facility (CORF): *Outpatient* rehabilitation services provided at a Comprehensive *Outpatient* Rehabilitation Facility (CORF).	80% of *Covered Services*, except for the annual Part B *Deductible* (subject to Medicare's CORF calendar year maximum benefit limit for combined physical therapy and occupational).	The annual Part B *Deductible* and 20% *Coinsurance*, subject to Medicare's CORF calendar year maximum benefit limit.	All charges after Medicare's calendar year CORF maximum benefit limit.

Part B Benefits (continued)			
Benefit	**Medicare Pays...**	**The *Plan* Pays…**	**You Pay…**
Medicare Diabetes Prevention Program (MDPP) MDPP services are covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavioral change intervention that provides practice training in long term dietary change, increased physical activity, and problem solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	100% of *Covered Services.*	Nothing.	Nothing.

Part B Benefits (continued)			
Benefit	**Medicare Pays...**	**The *Plan* Pays…**	**You Pay…**
Teleheatlh Services: Medicare covers office visits, psychotherapy, consultations, and certain other medical or health services provided by an eligible provider who is not at a member's location. These services are covered using an interactive, two-way telecommunications system (like real-time audio and video). Note: These services are available in rural areas, under certain conditions, but only if you are located at: a doctor's office, hospital, critical access hospital, Rural Health Clinic, Federally Qualified Health Center, hospital-based dialysis facility, skilled nursing facility, or community mental health center.	80% of Medicare-approved *Covered Services*, except for the annual Part B *Deductible.*	The annual Part B *Deductible* and 20% *Coinsurance*.	Nothing.
	Note: Additional services may be provided (outside of Part B) under this plan. For more information, see "Telemedicine services" in the "Other Covered Services Table" later in this chapter.		

Part B Benefits (continued)			
Benefit	**Medicare Pays...**	**The *Plan* Pays…**	**You Pay…**

<u>Acupuncture</u>
 	
Once Medicare provides coverage, Tufts Health Plan provides coverage up to the Allowed Charge for acupuncture for chronic low back pain (lasting 12 weeks or longer) for up to 12 visits in 90 days.
 	
• Coverage is available for up to 20 acupuncture treatments annually;
• An additional 8 sessions will be available to patients showing improvement.
• Treatment will be discontinued if no improvement or regression occurs.
• The cause of the lower back pain must be:
  ◦ A non-specific,non-identifiable systemic cause (for example, not associated with metastatic, inflammatory or infectious disease), or
  ◦ Not associated with surgery. Or
  ◦ Not associated with pregnancy.
	80% of *Covered Services*, except for the annual Part B *Deductible.*	The annual Part B Deductible and 20% *Coinsurance*.	Nothing.

Part B Benefits (continued)			
Benefit	**Medicare Pays...**	**The *Plan* Pays…**	**You Pay…**
<u>Opioid treatment program services</u> 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	Medicare Part B benefits for Opioid treatment program services covered in full.	Nothing.	Nothing.
<u>Pulmonary Rehabilitation Services (COPD)</u> 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.	Medicare benefits for Pulmonary Rehabilitation Services in full, except: • The Part B *Deductible* • The Part B *Coinsurance.*	…the following charges, [minus a $10 *Copayment* per visit: The Part B *Deductible* The Part B *Coinsurance.*	…the following charges, minus a $10 *Copayment* per visit: The Part B *Deductible* The Part B *Coinsurance.*

Part B Benefits (continued)			
Benefit	**Medicare Pays...**	**The *Plan* Pays…**	**You Pay…**
Urgently needed care 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.	Medicare benefits for Urgently needed care in full, except: • The Part B *Deductible* • The Part B *Coinsurance.*	• The Part B *Deductible* • The Part B *Coinsurance.*	Nothing.

Part B Benefits (continued)			
Benefit	**Medicare Pays...**	**The *Plan* Pays…**	**You Pay…**
<u>Vision Care</u> <u>The Plan provides coverage up to the Allowed Charge for the following services covered under this benefit:</u> • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age- related macular degeneration.	Medicare benefits in full for Vision Care services, **except**: • The Part B *Deductible* • The Part B *Coinsurance.*	• The Part B *Deductible* • The Part B *Coinsurance.*	Nothing.
• 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.	Medicare benefits in full for this screening.	Nothing.	Nothing.
• For people with diabetes, screening for diabetic retinopathy is covered once per year.	Medicare benefits in full for this screening.	Nothing.	Nothing.
Coverage is provided for 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.) Annual routine glasses, contacts, $150 allowance.	Medicare benefits in full up to the listed dollar cap.	Nothing.	Nothing, up to the listed dollar cap. Then, all charges above that cap.

Mental health and substance abuse services (Parts A and B) (continued)			
Benefit	**Medicare Pays...**	***Tufts HP* Pays…**	**You Pay…**
Outpatient mental health and substance abuse services* (Part B): *Outpatient* services for the diagnosis and treatment of a mental condition or substance abuse. Note: Psychopharmacological services and neuropsychological services are covered as "*Outpatient* Services" under Part A (as shown on page 28 above).	80% of *Covered Services*, except for the annual Part B *Deductible*.	The annual Part B *Deductible* and 20% *Coinsurance*, minus a $10 *Copayment*.	A $10 *Copayment* per visit.

Mental health and substance abuse services (Parts A and B) (continued)			
Benefit	**Medicare Pays...**	***Tufts HP* Pays…**	**You Pay…**
Opioid Use Disorder Treatment Services (Part B): Medicare covers opioid use disorder treatment services provided by opioid treatment programs. The services include medication, counseling, drug testing, and individual and group therapy. Counseling and therapy services are covered in person and by virtual delivery (using 2-way audio/video communication technology). You will pay nothing for these services if you get them from an opioid treatment provider who is enrolled in Medicare.	100% of *Covered Services* .	Nothing.	Nothing.

Other Covered Services table

The following table describes the services which the *Plan* covers, but Original Medicare may not cover.

Other *Covered Services* (outside of Medicare Parts A and B)		
Benefit	**The *Plan* Pays...**	**You Pay…**
Preventive care services: • Annual routine physical exams, including appropriate immunizations and lab tests as recommended by the physician; • hearing exams and screenings.	All *Covered Services*.	Nothing.

Foreign Travel:
Medicare pays Nothing for Emergency Room and Urgent Care services received outside of 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, and
	  • the remainder of charges.
		• The appropriate cost share depending on the services rendered:
		  • No charges for Emergency Room Care (if not admitted), or
		  • a $10 *Copayment* for an office visit.

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 Emergency Room and Urgent Care services that **Medicare would have covered** if you received them in the United States, the Plan provides benefits for both: • the Covered Services listed in this Description of Benefits; and • 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.		

Other Covered Services table The following table describes the services which the *Plan* covers, but Original Medicare may not cover.

Other *Covered Services* (outside of Medicare Parts A and B)		
Benefit	**The *Plan* Pays...**	**You Pay…**
Coverage is provided as described in this section for *Outpatient* contraceptive services, including consultations, examinations, procedures and medical services, which are related to the use of all contraceptive methods that have been approved by the United States Food and Drug Administration (FDA). <u>Family planning:</u> Services: • medical examinations; • consultations; • birth control counseling; and • genetic counseling.	All *Covered Services*, minus a $10 *Copayment* per visit.	A $10 *Copayment* per visit.
<u>Procedures:</u> • sterilization; and • pregnancy termination, as permitted under Massachusetts law.	<u>Office Visit:</u> All *Covered Services*, minus $10 *Copayment* per visit. <u>*Day Surgery:*</u> All *Covered Services*.	<u>Office Visit:</u> A $10 *Copayment* per visit. <u>*Day Surgery*:</u> Nothing.

Other Covered Services table

The following table describes the services which the *Plan* covers, but Original Medicare may not cover.

Other *Covered Services* (outside of Medicare Parts A and B)		
Benefit	**The *Plan* Pays...**	**You Pay…**
Dental services: • *Emergency* care: X-rays and *Emergency* oral surgery in an emergency room to temporarily stabilize damaged tissues or reposition sound, natural and permanent teeth that have moved or have broken due to injury. You must receive this care within 48 hours after the injury. The injury must have been caused by a source outside the mouth. • Non-*Emergency* care: • Except as specified below, all Non-*Emergency* oral health services performed in an *Inpatient* or *Day Surgery* setting must meet *Medical Necessity* guidelines in order to be covered. • Non-*Emergency* oral health services are not covered when performed in an office setting. • Hospital, physician, and surgical charges are covered for the following conditions: • Surgical treatment of skeletal jaw deformities; • Surgical treatment of cleft lip or cleft palate for *Children* under the age of 18; or • Surgical treatment for Temporomandibular Joint Disorder (TMJ).	All *Covered Services* minus a $10 *Copayment* per visit.	A $10 *Copayment* per visit.

Other Covered Services table The following table describes the services which the *Plan* covers, but Original Medicare may not cover.

Other *Covered Services* (outside of Medicare Parts A and B)		
Benefit	**The *Plan* Pays...**	**You Pay…**
<u>Dental services, continued:</u> • The costs of *Inpatient* services and *Day Surgery* for certain additional oral health services are covered in certain specific instances. For these services (see chart below) to be covered, **all** of the following clinical criteria must be met: • the *Member* cannot safely and effectively receive oral health services in an office setting: (1) due to being of young age; or (2) because of a specific and serious nondental organic impairment (for example, hemophilia), • the *Member* requires these services in order to maintain his/her health; AND • the services are not cosmetic or *Experimental*. • Surgical removal of impacted teeth when embedded in bone; • Surgical removal of unerupted teeth when embedded in bone; • Extraction of seven or more permanent teeth during one visit. Any other non-covered dental procedure that meets the above criteria.		

Other *Covered Services* (outside of Medicare Parts A and B) - continued		
Benefit	**The *Plan* Pays…**	**You Pay…**
Hospice Care Services We will cover the following services for Members who are terminally ill (having a life expectancy of 6 months or less): • *Provider* services; • nursing care provided by or supervised by a registered professional nurse; • social work services; • volunteer services; and • counseling services (including bereavement counseling services for the *Member's* family for up to one year following the *Member's* death). "Hospice care services" are defined as a coordinated licensed program of services provided, during the life of the *Member*, to a terminally ill *Member.* Such services can be provided: • in a home setting; • on an *Outpatient* basis; and • on a short-term *Inpatient* basis, for the control of pain and management of acute and severe clinical problems which cannot, for medical reasons, be managed in a home setting.	All *Covered Services*.	Nothing.

Other Covered Services table The following table describes the services which the *Plan* covers, but Original Medicare may not cover.

Other *Covered Services* (outside of Medicare Parts A and B)		
Benefit	**The *Plan* Pays...**	**You Pay…**
Cardiac rehabilitation: Services for *Outpatient* treatment of documented cardiovascular disease that: (1) meet the standards promulgated by the Massachusetts Commissioner of Public Health; and (2) are initiated within 26 weeks after diagnosis of cardiovascular disease. The *Plan* covers only the following services: * the *Outpatient* convalescent phase of the rehabilitation program following hospital discharge; and * the *Outpatient* phase of the program that addresses multiple risk reduction, adjustment to illness and therapeutic exercise. Note: The *Plan* does not cover the program phase that maintains rehabilitated cardiovascular health.	All *Covered Services*, minus a $10 *Copayment* per visit.	A $10 *Copayment* per visit.

Other *Covered Services* (outside of Medicare Parts A and B) - continued		
Benefit	**The *Plan* Pays…**	**You Pay…**
Bone marrow transplants for breast cancer: Bone marrow transplants for *Member*s diagnosed with breast cancer that has progressed to metastatic disease who meet the criteria established by the Massachusetts Department of Public Health.	All *Covered Services*.	Nothing.
Human Leukocyte Antigen Testing: 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. Includes: • costs of testing for A, B or DR antigens; or • any combination consistent with the rules and criteria established by the Department of Public Health.	All *Covered Services*, except for a $10 *Copayment* per visit.	A $10 *Copayment* per visit.

Other *Covered Services* (outside of Medicare Parts A and B) - continued		
Benefit	**The *Plan* Pays…**	**You Pay…**
<u>Nonprescription enteral formulas:</u> Coverage is provided: • For home use for treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility and chronic intestinal pseudo-obstruction. • When *Medically Necessary*: infant formula for milk or soy protein intolerance; formula for premature infants; and supplemental formulas for growth failure.	All *Covered Services*.	Nothing.
<u>Low Protein Foods:</u> When given to treat inherited diseases of amino acids and organic acids.	All *Covered Services*.	Nothing.
<u>Special Medical Formulas:</u> When *Medically Necessary* to protect the unborn fetuses of women with PKU.	All *Covered Services*.	Nothing.

Other *Covered Services* (outside of Medicare Parts A and B) - continued		
Benefit	**The *Plan* Pays…**	**You Pay…**
Diabetes self-management and educational training services: *Outpatient* self-management training and educational services, including medical nutrition therapy, used to diagnosis or treat insulin-dependent diabetes, non-insulin dependent diabetes, or gestational diabetes.	All *Covered Services*, except for a $10 *Copayment* per visit. Note: These services are also covered under your Medicare Part B benefits. For more information, see "Diabetes self-management training" under the "Part B Benefits" section earlier in this chapter.	A $10 *Copayment* per visit. Note: These services are also covered under your Medicare Part B benefits. For more information, see "Diabetes self-management training" under the "Part B Benefits" section earlier in this chapter.
Scalp hair prostheses or wigs for cancer or leukemia patients: Scalp hair prostheses or wigs worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia.	All *Covered Services*, up to a maximum benefit of $350 per calendar year.	For all services **after** the $350 calendar year maximum benefit has been reached.
Patient care services provided pursuant to a qualified clinical trial As required by applicable law, patient care services provided pursuant to a qualified clinical trial for the treatment of cancer to the same extent as those *Inpatient* or *Outpatient* services would be covered if the *Member* did not receive care in a qualified clinical trial.	*Inpatient* care: All *Covered Services*. *Outpatient* care: All *Covered Services*.	*Inpatient* care: Nothing. *Outpatient* care: Nothing.

Other *Covered Services* (outside of Medicare Parts A and B) - continued

Benefit

Autism spectrum disorders – diagnosis and treatment (continued)

For more information about these programs, call the *Tufts Health Plan* Behavioral Health Department at 1-800-208-9565;

- services provided by licensed or certified speech therapists, occupational therapists, physical therapists, or social workers. **Note:** Visit limits for services described under the "Rehabilitative physical or occupational therapy" benefit do not apply to coverage for autism spectrum disorders.
- prescription medications, covered under the *Tufts Health Plan* "Coverage for Other Prescription Drugs" section, described later in this chapter;
- psychiatric and psychological care, covered under the "Mental Health and Substance Abuse Services" benefit described earlier in this chapter; and
- therapeutic care (including services provided by licensed or certified speech therapists, occupational therapists, physical therapists, or social workers.

****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.**

Other *Covered Services* (outside of Medicare Parts A and B) - continued

Benefit

Cleft lip and cleft palate treatment and services for children

In accordance with Massachusetts law, the following services are covered for children under the age of 18 who are covered under this plan:

- **Medical and facial surgery:** Coverage is provided for *Day Surgery* and *Inpatient* hospital admissions. 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**.

Services must be prescribed by the treating physician or surgeon, and that *Provider* must certify that the services are *Medically Necessary* and are required because of the cleft lip or cleft palate.

NOTE: The next three pages in this *Description of Benefits* list the *Cost Sharing Amounts* that apply to these *Covered Services* under this plan.

Other *Covered Services* (outside of Medicare Parts A and B) - continued		
Benefit	**The *Plan* Pays…**	**You Pay…**
Cleft lip and cleft palate treatment and services for children - continued	**Medical or facial surgery:** • *Inpatient* services: All *Covered Services*. • *Day Surgery*: All *Covered Services*.	**Medical or facial surgery:** • *Inpatient* services: Nothing. • *Day Surgery*: Nothing.
	Nutrition services: All *Covered Services*, minus a $10 *Copayment* per visit.	**Nutrition services:** A $10 *Copayment* per visit.

Other *Covered Services* (outside of Medicare Parts A and B) - continued		
Benefit	**The *Plan* Pays…**	**You Pay…**
Cleft lip and cleft palate treatment and services for children - continued	**Oral surgery:** • Office Visit: All *Covered Services*, minus a $10 *Copayment* per visit. • Emergency room: • All *Covered Services.* • *Inpatient* services: All *Covered Services*. • *Day Surgery*: All *Covered Services*.	**Oral surgery:** • Office Visit: A $10 *Copayment* per visit. • Emergency room: Nothing. • *Inpatient* services: Nothing. • *Day Surgery*: Nothing.
	Dental surgery or orthodontic treatment and management: Covered in full.	**Dental surgery or orthodontic treatment and management:** Nothing.
	Preventive and restorative dentistry: Covered in full.	**Preventive and restorative dentistry:** Nothing.
	Speech therapy and audiology services: All Covered Services, minus a $10 *Copayment* per visit.	**Speech therapy and audiology services:** All Covered Services, minus a $10 *Copayment* per visit.

Other *Covered Services* (outside of Medicare Parts A and B) - continued		
Benefit	**The *Plan* Pays…**	**You Pay…**
Oral medications for the treatment of cancer	Covered in full.	Nothing.
Telemedicine Services		
Office visit	All Covered Services , minus a $10 *Copayment* per visit]	Nothing.
Remote Patient Monitoring	All charges	Nothing
Remote medical data transfer/evaluation	All charges	Nothing

Coverage is provided for *Medically Necessary* telemedicine services for the purpose of diagnosis, consultation, or treatment in the same manner as an in-person consultation between you and your Tufts HP Provider. Telemedicine visits are provided through audio, video, or other electronic media communications. They substitute for in-person consultations with Tufts HP Providers when determined to be medically appropriate. These visits are available for both medical services and behavioral health services. This includes audio only consultations.

In addition, coverage is provided for additional telemedicine services that are not considered telemedicine visits, including:

- Remote patient monitoring services to collect and interpret clinical data while the Member remains at a distant site, either in real-time or not; and
- Remote evaluation of transferred medical data recorded on an electronic device for the purpose of diagnostic and therapeutic assistance in the care of the Member.

Telemedicine services with Tufts HP Providers follow the same rules about referrals that apply for in-person services with those Providers. Please see Chapter 1 for more information about referral requirements.

Other *Covered Services* (outside of Medicare Parts A and B) - continued

PRESCRIPTION DRUGS COVERED BY MEDICARE

Prescription Drugs Covered By Medicare: Medicare provides coverage for certain prescription drugs used to treat certain medical conditions, including certain injectable medications, when those drugs are obtained and administered by a physician. The physician will bill Medicare, and if the drug meets Medicare's coverage guideline, Medicare will pay for 80% of the Medicare approved charge for that drug. Then, this Medicare Complement *Plan* will pay the remainder of the Medicare approved amount for the drug. *Medically Necessary* hypodermic needles and syringes required to inject these medication are also covered under this section of the Prescription Drug Benefit.

Note: Infused medications and their administration are not covered in the home setting (home infusion) under this Medicare Complement Plan, unless Medicare covers the infused medication and/or its administration as the primary payor. *Tufts Health Plan* will cover any remainder of the cost up to the Medicare allowed amount. *Medically Necessary* hypodermic needles and syringes required to inject these medications are also covered under this section of the Prescription Drug Benefit.

For more information about coverage under this Medicare Complement Plan, call Member Services at 1-800-462-0224.

Other *Covered Services* (outside of Medicare Parts A and B) - continued

COVERAGE FOR OTHER PRESCRIPTION DRUGS

PRESCRIPTION DRUG BENEFIT

Introduction: This section of the Prescription Drug Benefit describes coverage for other prescription drugs under this Medicare Complement *Plan* including certain injectable drugs not covered by Medicare. The following topics are included in this section to explain your prescription drug coverage: *How Prescription Drugs Are Covered*; *Prescription Drug Coverage Table*; *What is Covered*; *What is Not Covered*; *Tufts HP Pharmacy Management Programs*; and *Filling Your Prescription*.

Italicized words are defined in the Glossary in Appendix A.

How Prescription Drugs Are Covered: Prescription drugs will be considered *Covered Services* only if they comply with the *Tufts HP Pharmacy Management Programs* section described below and are: listed below under *What is Covered*; provided to treat an injury, illness, or pregnancy; or *Medically Necessary*.

For a current list of *Covered Services*, please go to our website **or call** a Member Representative at 1-800-462-0224.

The *Prescription Drug Coverage Table* below describes your prescription drug benefit amounts.

- Tier-1 drugs have the lowest level *Cost Sharing Amount*.
- Tier-2 drugs have the middle level *Cost Sharing Amount*.
- Tier-3 drugs have the highest level *Cost Sharing Amount*.

IMPORTANT NOTE: Prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells are covered in full for up to a 30-day supply when filled at a *Tufts Health Plan* designated pharmacy.

- Smoking cessation agents (both prescription and generic over-the-counter agents when prescribed by a *Provider*) are covered in full.
- Most generic drugs are covered on Tier 1 or Tier 2.
- Pursuant to applicable law, naloxone (an opioid antagonist) is available without a prescription when obtained from a Massachusetts pharmacy. Whoever requests naloxone at a pharmacy will billed for the medication, even if that person is picking up the medication for someone else.

COVERAGE FOR OTHER PRESCRIPTION DRUGS - continued

Other *Covered Services* (outside of Medicare Parts A and B) - continued

PRESCRIPTION DRUG BENEFIT - continued

Where to fill prescriptions: You can fill your prescriptions at any *Tufts HP* designated pharmacy. *Tufts HP* designated pharmacies include:

- for the majority of prescriptions, most of the pharmacies in Massachusetts and additional pharmacies nationwide; and
- for a select number of drug products, a small number of special designated pharmacy providers. (For more information about *Tufts Health Plan*'s special designated pharmacy program, see "*Tufts HP* Pharmacy Management Programs" later in this Prescription Drug Benefit section.) If you have questions about where to fill your prescription, call the *Tufts Health Plan* Member Services Department at 1-800-462-0224.

How to fill prescriptions:

- Make sure the prescription is written by a *Tufts HP* participating *Provider*, except in cases of authorized referral or in Emergencies.
- When you fill a prescription, present your Member ID card at any *Tufts HP* designated pharmacy and pay your *Copayment*.
- If the cost of your prescription is less than your *Cost Sharing Amount*, then you are responsible for the actual cost of the prescription.
- If you have any problems using this benefit at a *Tufts HP* designated pharmacy, call the *Tufts Health Plan* Member Services Department at 1-800-462-0224.

Important: Your prescription drug benefit is honored only at *Tufts HP* designated pharmacies. In cases of Emergency, please call the *Tufts HP* Member Services Department at 1-800-462-0224 for instructions about submitting your prescription drug claims for reimbursement.

COVERAGE FOR OTHER PRESCRIPTION DRUGS - continued

Other *Covered Services* (outside of Medicare Parts A and B) - continued

PRESCRIPTION DRUG BENEFIT - continued

Filling Prescriptions for Maintenance Medications:

If you are required to take a *maintenance* medication, *Tufts HP* offers you two choices for filling your prescription medications:

- you may obtain your maintenance medication directly from a *Tufts HP* designated retail pharmacy; or
- you may have most maintenance medications* mailed to you through a *Tufts HP* designated mail services pharmacy.

*The following may not be available to you through a *Tufts HP* designated mail services pharmacy:

- medications for short term medical conditions;
- certain controlled substances and other prescribed drugs that may be subject to exclusions or restrictions;
- medications that are part of *Tufts HP*'s Dispensing Limitations program; or
- medications that are part of *Tufts HP*'s Special Designated Pharmacy program.

Note: Your *Cost Sharing Amounts* for maintenance medications are shown in the *Prescription Drug Coverage Table* below.

COVERAGE FOR OTHER PRESCRIPTION DRUGS - continued			
Other *Covered Services* (outside of Medicare Parts A and B) - continued			
PRESCRIPTION DRUG COVERAGE TABLE			
Benefit	**PRESCRIPTION DRUGS THAT…**		
	QUALIFY AS *COVERED SERVICES*, AS DESCRIBED BELOW.		**DO NOT QUALIFY AS *COVERED SERVICES*, AS DESCRIBED BELOW.**
	The *Plan* Pays…	**You Pay…**	**You Pay…**
Prescription Drug Benefit, as described below.	All *Covered Services*, except for the applicable *Copayment* as shown in the *Prescription Drug Coverage Table.*	The applicable *Copayment* for covered prescription drugs as shown in the *Prescription Drug Coverage Table.*	All charges.
Benefit Description	**Coverage**		
DRUGS OBTAINED AT A RETAIL PHARMACY*: Covered prescription drugs (including both acute and maintenance drugs), when you obtain them directly from a *Tufts HP* designated retail pharmacy.	**All other covered prescription drugs obtained at a retail pharmacy. You pay:** **Tier-1 drugs**: • $10 for up to a 30-day supply • $20 for a 31-60 day supply • $30 for a 61-90 day supply **Tier-2 drugs:** • $20 for up to a 30-day supply • $40 for a 31-60 day supply • $60 for a 61-90 day supply **Tier-3 drugs:** • $35 for up to a 30-day supply • $70 for a 31-60 day supply • $105 for a 61-90 day supply		

COVERAGE FOR OTHER PRESCRIPTION DRUGS - continued	
Other *Covered Services* (outside of Medicare Parts A and B) - continued	
PRESCRIPTION DRUG BENEFIT – continued	
DRUGS OBTAINED THROUGH A MAIL SERVICES PHARMACY: Most maintenance medications, when mailed to you through a *Tufts HP* designated mail services pharmacy.	**Tier-1 drugs**: • $20 for up to a 90-day supply **Tier-2 drugs:** • $40 for up to a 90-day supply **Tier-3 drugs:** • $70 for up to a 90-day supply
Note: If you fill your prescription in a state that allows you to request a brand-name drug even though your physician authorizes the generic equivalent, you will pay the applicable tier *Cost Sharing Amount* plus the difference in cost between the brand-name drug and the generic drug.	

COVERAGE FOR OTHER PRESCRIPTION DRUGS - continued

Other *Covered Services* (outside of Medicare Parts A and B) - continued

PRESCRIPTION DRUG BENEFIT – continued

What Is Covered:

Tufts HP covers the following under this Prescription Drug Benefit:

- Prescribed drugs (including hormone replacement therapy for peri and post-menopausal women) that by law require a prescription and are not listed under *What is Not Covered* (see "Important Notes" below).
- Insulin, insulin pens, insulin needles and syringes; oral diabetes medications that influence blood sugar levels; and urine glucose and ketone monitoring strips. Please see Part B – Benefits (page25) for information about coverage for lancets and blood glucose strips;
- Contraceptives, including oral contraceptives, diaphragms, and other self-administered hormonal contraceptives (e.g., patches, rings) that by law require a prescription, and FDA-approved over-the-counter female contraceptives (e.g., female condoms or contraceptive spermicides) when prescribed by a licensed *Provider* and dispensed at a pharmacy pursuant to a prescription, are covered as follows:
- Generic contraceptives are covered in full.
- Brand name contraceptives without a generic equivalent are covered in full.
- Brand name contraceptives with a generic equivalent are subject to the applicable *tier Copayment.* The only exception to this is when the generic equivalent is deemed by your physician to be medically inappropriate for you. In this case, the brand name contraceptive will be covered in full. The prescriber's statement of medical necessity is required.

  Note: This Prescription Drug Benefit only describes coverage for oral contraceptives, diaphragms, Depo-Provera, and other self-administered hormonal contraceptives (e.g., patches, rings) that by law require a prescription, and FDA-approved over-the-counter female contraceptives when prescribed by a licensed *Provider* and dispensed at a pharmacy pursuant to a prescription. See "Family Planning" earlier in this chapter for information about other contraceptive drugs and devices that qualify as *Covered Services*.
- Prefilled sodium chloride for inhalation (both prescription and over-the-counter)
- Off-label use of FDA-approved prescription drugs used in the treatment of cancer or HIV/AIDS which have not been approved by the FDA for that indication, provided, however, that such a drug is recognized for such treatment:
  - in one of the standard reference compendia;
  - in the medical literature; or
  - by the Commissioner of Insurance.

COVERAGE FOR OTHER PRESCRIPTION DRUGS - continued
Other *Covered Services* (outside of Medicare Parts A and B) - continued
PRESCRIPTION DRUG BENEFIT – continued

What Is Covered, continued:

- Compounded medications, if at least one active ingredient requires a prescription by law.
- Over-the-counter drugs included in the list of covered drugs on the formulary applicable to your plan when prescribed by a *Provider*. You may find the formulary on our website or you can call Member Services for more information.
- Prescription smoking cessation agents.
- Certain medications used for bowel preparation in colonoscopy procedures are covered in full for *Members* ages 45 through 74. For more information, please call Member Services or see the formulary on our website.
  Note: Certain prescription drugs products may be subject to one of the *Tufts HP Pharmacy Management Programs* described below.

COVERAGE FOR OTHER PRESCRIPTION DRUGS - continued

Other *Covered Services* (outside of Medicare Parts A and B) - continued

PRESCRIPTION DRUG BENEFIT - continued

What Is Not Covered:

The *Plan* does not cover the following under this Prescription Drug Benefit:

- Prescription and over-the-counter homeopathic medications.
- Drugs that by law do not require a prescription (unless listed as covered in the *What is Covered* section above).
- Drugs that are part of our "Non-Covered Drugs with Suggested Alternatives" pharmacy management program unless they are approved for coverage for you through the medical review process. See "Pharmacy Management Programs" and "Important Notes" later in this chapter.
- Vitamins and dietary supplements (except prescription prenatal vitamins).
- Topical and oral fluorides for adults.
- Medication for the treatment of idiopathic short stature.
- Cervical caps, IUDs, implantable contraceptives (e.g., Implanon® (etonorgestrel), levonorgestrel implants), Depo-Provera or its generic equivalent [(these are covered under your *Outpatient* care benefit earlier in this chapter)], [oral contraceptives, diaphragms, and other hormonal contraceptives (e.g., patches, rings) that by law require a prescription, and FDA-approved female over-the-counter contraceptives when prescribed by a licensed *Provider* and dispensed at a pharmacy pursuant to a prescription.
- Experimental drugs: drugs that cannot be marketed lawfully without the approval of the FDA and such approval has not been granted at the time of their use or proposed use or such approval has been withdrawn.
- Products that are FDA approved as devices, including therapeutic or other prosthetic devices, appliances, supports, or other non-medical products. These may be provided as described earlier in this chapter.
- Immunization agents. These may be provided under Preventive health care earlier in this chapter.
- Prescriptions written by physicians who do not participate in *Tufts HP*, except in cases of authorized referral or Emergency care.
- Prescriptions filled at pharmacies other than *Tufts HP* designated pharmacies, except for Emergency care.
- Drugs for asymptomatic onychomycosis, except for *Member*s with diabetes, vascular compromise, or immune deficiency status.
- Over-the-counter medications if not included on the list of covered drugs on our website.
- Drugs classified as Schedule I controlled substances by the FDA (e.g., marijuana

COVERAGE FOR OTHER PRESCRIPTION DRUGS - continued

Other *Covered Services* (outside of Medicare Parts A and B) - continued

PRESCRIPTION DRUG BENEFIT - continued

What Is Not Covered, continued:

- Acne medications, unless *Medically Necessary*.
- Drugs which are dispensed in an amount or dosage that exceeds *Tufts HP*'s established dispensing limitations.
- Compounded medications, if no active ingredients require a prescription by law.
- Prescriptions filled through an internet pharmacy that is not a Verified Internet Pharmacy Practice Site certified by the National Association of Boards of Pharmacy.
- Prescription medications once they become available over-the-counter. In this case, the specific medication may not be covered and the entire class of prescription medications may also not be covered. For more information, call Member Services or check our website.
- Prescription medications when packaged with non-prescription products.
- Oral non-sedating antihistamines.
- Prescription medications when medications with the same active ingredient or a modified version of an active ingredient that is therapeutically equivalent to a covered prescription medication are available over-the-counter. In this case, the specific medication may not be covered and the entire class of prescription medications may also not be covered. Some examples of these excluded medications are: topical acne medications with benzoyl peroxide ≤ 10%; H_2 blockers with nizatidine, famotidine, cimetidine, or ranitidine; and oral non-sedating antihistamines. For a complete list of these excluded medications, call Member Services or check our website.

COVERAGE FOR OTHER PRESCRIPTION DRUGS - continued

Other *Covered Services* (outside of Medicare Parts A and B) - continued

PRESCRIPTION DRUG BENEFIT - continued

***Tufts HP* Pharmacy Management Programs:**

In order to provide safe, clinically appropriate, cost-effective medications under this Prescription Drug Benefit, *Tufts HP* has developed the following Pharmacy Management Programs:

Quantity Limitations Program:

Tufts HP limits the quantity of selected medications that *Members* can receive in a given time period, for cost, safety and/or clinical reasons.

Prior Authorization Program:

Tufts HP restricts the coverage of certain drug products that have a narrow indication for usage, may have safety concerns and/or are extremely expensive, requiring the prescribing physician to obtain prior approval from *Tufts HP* for such drugs.

Step Therapy PA Program

Step therapy is a type of prior authorization program (usually automated) that uses a step-wise approach, requiring the use of the most therapeutically appropriate and cost-effective agents first, before other medications may be covered. *Members* must first try one or more medications on a lower step to treat a certain medical condition before a medication on a higher step is covered for that condition.

Special Designated Pharmacy Program (Mail Order):

Tufts HP has designated special pharmacies to supply a select number of medications via mail order, including medications used in the treatment of infertility, multiple sclerosis, hemophilia, hepatitis C, growth hormone deficiency, rheumatoid arthritis, and cancers treated with oral medications. These pharmacies specialize in providing medications used to treat certain conditions and are staffed with clinicians to provide support services for *Members*. Medications may be added to this program from time to time. Special pharmacies can dispense up to a 30-day supply of medication at one time and it is delivered to the *Member's* home via mail. This is NOT part of the mail order pharmacy benefit. Extended day supplies and *Copayment* savings do not apply to these special designated drugs.

Non-Covered Drugs with Suggested Alternatives:

While *Tufts Health Plan* covers over 4,500 drugs, a small number of drugs (less than 1%) are not covered because there are safe, effective and more affordable alternatives available. These non-covered drugs are listed in Appendix B. All of the alternative drug products are approved by the U.S. Food and Drug Administration (FDA) and are widely used and accepted in the medical community to treat the same conditions as the medications that are no longer covered.

COVERAGE FOR OTHER PRESCRIPTION DRUGS - continued

Other *Covered Services* (outside of Medicare Parts A and B) - continued

PRESCRIPTION DRUG BENEFIT - continued

***Tufts HP* Pharmacy Management Programs, continued**

New-To-Market Drug Evaluation Process:

Tufts HP's Pharmacy and Therapeutics Committee reviews new-to-market drug products for safety, clinical effectiveness and cost. *Tufts HP* then makes a coverage determination based on the Pharmacy and Therapeutics Committee's recommendation. A new drug product will not be covered until this process is completed – usually within 6 months of the drug product's availability.

IMPORTANT NOTES:

- If your physician feels it is *Medically Necessary* for you to take medications that are restricted under any of the *Tufts HP Pharmacy Management Programs* described above, he or she may submit a request for coverage. *Tufts HP* will approve the request if it meets our guidelines for coverage. For more information, you can call a Member Representative at 1-800-462-0224.
- The *Tufts Health Plan* website has a list of covered drugs with their tiers. *Tufts HP* may change a drug's tier during the year. For example, if a brand drug's patent expires, *Tufts HP* may change the drug's status by either (a) moving the brand drug from tier 2 to tier 3 or (b) moving the brand drug to our list of non-covered drugs when the generic drug becomes available.
- If you have questions about your prescription drug benefit, would like to know the tier of a particular drug, or would like to know if your medication is part of a Pharmacy Management Program, check our website, or call a Member Representative at 1-800-462-0224.

Exclusions from Benefits

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 received outside the *Tufts HP Service Area*, except as described under "How the Plan Works" in Chapter 1.
- 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:
  - long-term antibiotic treatment of chronic Lyme disease;
  - bone marrow transplants for breast cancer;
  - patient care services provided pursuant to a qualified clinical trial for the treatment of cancer; or
  - Off-label uses of prescription drugs for the treatment of cancer or HIV/AIDS.

  If the treatment is *Experimental or Investigative*, the *Plan* 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 in a Prescription Drug Benefit earlier in this chapter. Medications and other products which can be purchased over-the-counter except those listed as covered under the Prescription Drug Benefit. Laboratory tests ordered by a *Member* (online or through the mail), even if performed at a licensed laboratory.
- Injectable medications, except as described earlier in this chapter.
- Infused medications and their administration are not covered in the home setting (home infusion) under this *Tufts* Medicare Compliment plan, unless Medicare covers the infused medication and/or its administration as the primary payor. *Tufts Health Plan* will cover any remainder of the cost up to the Medicare allowed amount.

Exclusions from Benefits, continued

- The following exclusions apply to services provided by the relative of a *Member:*
  - Services provided by a relative who is not a *Tufts Health Plan Provider,* whether or not the services are authorized by your *PCP*, are not covered.
  - Services provided by an immediate family member (by blood or marriage), even if the relative is a *Tufts Health Plan Provider* and the services are authorized by your *PCP,* are not covered.
- If you are a *Tufts Health Plan Provider,* you cannot provide or authorize services for yourself, be your own *PCP,* or be the *PCP* of 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.
- 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.
- Facility charges or related services if the procedure being performed is not a Covered Service.
- Preventive dental care; periodontal treatment; orthodontics; dental supplies; dentures; restorative services including, but not limited to, crowns, fillings, root canals, and bondings; skeletal jaw surgery, except as provided under “dental services” earlier in this chapter; alteration of teeth; care related to deciduous (baby) teeth; splints and oral appliances including those for TMJ disorders. This exclusion does not apply to the treatment of cleft lip or cleft palate for children under the age of 18, as described under “Cleft lip or cleft palate treatment and services for children” earlier in this chapter.
- Surgical removal or extraction of teeth, except as provided under “Dental Services” earlier in this chapter.
- Cosmetic (meaning to change or improve appearance) surgery, procedures, supplies, medications or appliances, except as provided earlier in this chapter. Breast reconstruction is covered when following a *Medically Necessary* mastectomy, as described in “Hospital *Inpatient* Care (Part A) earlier in this chapter.
- Rhinoplasty; liposuction; and brachioplasty.
- Treatment of spider veins; removal or destruction of skin tags.

Exclusions from Benefits, continued

- Hair removal (e.g., electrolysis, laser hair removal), except when *Medically Necessary* to treat an underlying skin condition or for skin preparation for transgender genital surgery.
- Costs associated with home births.
- Circumcisions performed in any setting other than a hospital, *Day Surgery*, or a physician's office.
- Infertility services, infertility medications, and associated reproductive technologies (such as IVF, GIFT, and ZIFT) including, but not limited to, experimental infertility procedures; reversal of voluntary sterilization; sperm or embryo cryopreservation; donor sperm and associated laboratory services, costs associated with donor recruitment and compensation; sterilizations; and Infertility services which are necessary for conception as a result of voluntary sterilization or following an unsuccessful reversal of a voluntary sterilization.

  The costs of surrogacy, which means all costs incurred by a fertile woman to achieve a pregnancy as a surrogate or gestational carrier for an infertile *Member*. These costs include, but are not limited to: (1) use of a donor egg and a gestational carrier; (2) costs for drugs necessary to achieve implantation in a surrogate, embryo transfer, and cryopreservation of embryos; and (3) costs for maternity care if the surrogate is not a *Member.* A surrogate is a person who carriers and delivers a child for another either through artificial insemination or surgical implantation of an embryo. A gestational carrier is a surrogate with no biological connection to the embryo/child.
- Preimplantation genetic testing and related procedures performed on gametes or embryos.
- Reversal of voluntary sterilization; or over-the-counter contraceptive agents.
- Human organ transplants, if not covered by Medicare.
- The purchase of electric hospital grade breast pump; donor breast milk.
- Services provided to a non-*Member*, except as described earlier in this chapter.
- Acupuncture.
- Psychoanalysis.
- *Inpatient* and *Outpatient* weight-loss programs and clinics, except as described earlier in this chapter.
- Biofeedback, except for the treatment of urinary incontinence; neuromuscular stimulators and related supplies.
- Hypnotherapy; relaxation therapies; massage therapies, except as described under services by a personal trainer; exercise classes; cognitive rehabilitation programs or cognitive retraining programs, except as described earlier in this chapter. Also excluded are diagnostic services related to any of these procedures or programs.

Exclusions from Benefits, continued

- Blood, blood donor fees, blood storage fees, or blood substitutes; blood banking, cord blood banking and blood products, except as detailed in the "Note" below.

Note: The following blood services and products are covered:

- blood processing;
- blood administration;
- Factor products (monoclonal and recombinant) for Factor VIII deficiency (classic hemophilia), Factor IX deficiency (Christmas factor deficiency), and von Willebrand disease;
- intravenous immunoglobulin for treatment of severe immune disorders, certain neurological conditions, infectious conditions, and bleeding disorders.

- 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 clinics), 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.* Devices and procedures intended to reduce snoring including, but not limited to, laser-assisted uvulopalatoplasty, somnoplasty, and snore guards.
- Examinations, evaluations or services for educational or developmental purposes, including physical therapy, speech therapy, and occupational therapy, except as provided earlier in this chapter. Vocational rehabilitation services and vocational retraining. Also services to treat learning disabilities, behavioral problems, and developmental delays and services to treat speech, hearing and language disorders in a school-based setting. The term “developmental” refers to a delay in the expected achievement of age-appropriate fine motor, gross motor, social, or language milestones that is not caused by an underlying medical illness or condition.
- Routine eye exams, eyeglasses, lenses or frames; or refractive eye surgery (including radial keratotomy) for conditions which can be corrected by means other than surgery.

Exclusions from Benefits, continued

- Contact lenses or contact lens fitting.
- Hearing aids.
- Hearing exams and screenings, except as described earlier in this Chapter.
- Methadone treatment and methadone maintenance related to substance abuse disorders.
- Private duty nursing (block or non-intermittent nursing.
- 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.

  Note: 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.

- Transportation, including, but not limited to, transportation by chair car, wheelchair van, or taxi, except as described in "Ambulance Services" in this Chapter.
- Lodging related to receiving any medical service.
- Intra-articular hyaluronan injections (e.g., viscosupplements, Euflexxa, Synvisc).
- All *Non-Conventional Medicine* services, provided independently or together with conventional medicines, and all related testing, laboratory testing, services, supplies, procedures and supplements associated with this type of medicine.
- Service or therapy animals and related supplies.

Chapter 4
When Coverage Ends

Overview

Reasons coverage ends

Coverage ends when any of the following occurs:

- you lose eligibility because you
  - no longer meet the Plan's eligibility rules, or
  - no longer are eligible for and enrolled in Parts A and B of Medicare (please refer to your Medicare Handbook for events that can change your Medicare coverage),
- you choose to drop coverage,
- you commit an act of physical or verbal abuse unrelated to your physical or mental condition which poses a threat to: any *Provider*; any *Tufts HP Member*; or *Tufts Health Plan* or any *Tufts HP* employee,
- misrepresentation or fraud, or
- The City's contract with *Tufts HP* ends.

Benefits after termination

The *Plan* will <u>not</u> pay for services you receive after your coverage ends even if

- you were receiving *Inpatient* or *Outpatient* care when your coverage ended, or
- you had a medical condition (known or unknown), including pregnancy, that requires medical care after your coverage ended.

When a Member is No Longer Eligible

Your coverage ends on the date you

- no longer meet the *Plan's* eligibility rules, or
- no longer are eligible for and enrolled in Parts A and B of Medicare.

<u>Important Note</u>: 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 you no longer want coverage and you meet any qualifying event the *City* requires. To end your coverage, notify the *Plan* at least 30 days before the date you want your coverage to end. You must pay *Premiums* up through the day your coverage ends.

Membership Termination for Acts of Physical or Verbal Abuse

Coverage may terminate if you commit acts of physical or verbal abuse which:

- are unrelated to your physical or mental condition;
- pose a threat to:
  - any *Provider*,
  - any *Tufts HP Member*, or
  - *Tufts Health Plan* or any *Tufts HP* employee.

Membership Termination for Misrepresentation or Fraud

Coverage may be terminated for misrepresentation or fraud. If your coverage is terminated for misrepresentation or fraud, *Tufts HP* may not allow you to re-enroll for coverage with *Tufts HP* under any other plan (such as another employer's plan) or type of coverage (for example, coverage as a Spouse).

Examples of misrepresentation or fraud include:

- false or misleading information on your application;
- receiving benefits for which you are not eligible;
- keeping for yourself payments made by the *Plan* that were intended to be used to pay a *Provider*;
- abuse of the benefits under this plan, including the resale or transfer of supplies, medication or equipment provided to you as *Covered Services*;
- submission of any false paperwork, form, or claims information; or
- allowing someone else to use your Member ID card.

Date of termination

The City will terminate coverage by sending notice of termination to the employee's last address as shown on the City records. Termination will be retroactive to the Effective Day, unless the City determines that the termination shall be retroactive to the date of the misrepresentation or fraud or to such late date as the City designates in the notice of termination.

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 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 not enough to pay for that care, the *Plan*, at its option, may:

- 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 the *City*.

Termination of the Contract Between the City and *Tufts HP*

End of *Tufts HP*'s and the City's relationship

Coverage will terminate if the relationship between the City and *Tufts HP* ends for any reason, including

- the City's contract with *Tufts HP* terminates;
- the City fails to pay contributions for coverage on time;
- *Tufts HP* no longer offers this Medicare Complement plan; or
- *Tufts HP* stops operating.

Chapter 5
Member Satisfaction

Overview

Introduction This chapter contains information about:

- the *Member* Satisfaction Process, which addresses the *Member* Grievance Process and the Internal *Member* Appeals Process;
- concerns about quality of medical care;
- administrative concerns about *Tufts HP*;
- bills from *Providers*; and
- limitation on actions.

Important Notes about Appeals and Grievances:

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

Address and telephone number

If you write to *Tufts HP*, send the letter to the Appeals and Grievances Department at this address:

Tufts Health Plan
Attn: Appeals and Grievances Dept.
705 Mount Auburn Street
P.O. Box 9193
Watertown, MA 02472-9193

If you need to call *Tufts HP* about a concern or appeal, contact a Member Representative at 1-800-462-0224.

How to File a Claim

Filing Claims

In many instances, the *Provider* will bill *Tufts HP* directly for supplemental payment. In the event that you are billed directly for supplemental payment (such as in the case of a *Provider* who does not accept assignment), you must submit a receipted bill, along with the Medicare Explanation of Benefits to *Tufts HP*. Receipts must show the name of the *Member*, the date of services, the type of service, and proof of payment. If a receipted bill is not sent, then payment will be made directly to the *Provider*. *Tufts HP* will not be able to process claims unless we have the Explanation of Benefits which shows the amount Medicare has allowed for charges that have been incurred.

To Obtain Claim Forms

Claim forms are available from the City or by calling *Tufts HP* at 1-800-462-0224.

Send completed claim forms to:

Tufts Health Plan
705 Mount Auburn Street
P.O. Box 9171
Watertown, MA 02472- 9171

Member Satisfaction Process

Process Summary

Tufts HP has a Member Satisfaction Process to address your concerns as expeditiously as possible. This process addresses:

- Internal Inquiry;
- Member Grievance Process; and
- appeals, including:
  - Internal Member Appeals; and
  - Expedited Appeals.

All grievances and appeals should be sent to *Tufts HP* at the following address:

Tufts Health Plan
Attn: Appeals and Grievances Dept.
705 Mt. Auburn Street
P.O. Box 9193
Watertown, MA 02472-9193

All calls should be directed to *Tufts HP*'s Member Services at **1-800-462-0224**.

Internal Inquiry

Call a *Tufts HP* Member Representative 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 a Member Representative that you are not satisfied with the response you have received from *Tufts HP*, 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 HP* or a *Tufts HP 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 *Tufts HP* 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 a *Tufts Health Plan* Member Representative, who 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 HP* Member ID card 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" section below.

Administrative Grievance

- Whether you file your grievance in writing or verbally 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 Grievance Specialist coordinating the review of your grievance.
-
- *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 *Tufts HP*.

Clinical Grievances

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

Whether you file your grievance in writing or verbally, we will notify you by mail, within five (5) business days after receiving your grievance, that your grievance has been received and provide you with the name, address, and telephone number of the Grievance Specialist coordinating the review of your grievance. We will also include the name, address, and telephone number of the person coordinating the review.

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

Medicare

In many instances, we will ask you to direct your initial concern to Medicare (since Medicare will make the primary determination on your health care benefits). Information is available by contacting your local Social Security office or via the internet on the official Medicare website at www.medicare.gov.

Internal Member Appeals

Requests for services that are specifically excluded in this *Description of Benefits* or for coverage determinations based on medical necessity 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.

Internal Member Appeals, continued

You can submit a verbal appeal of a benefit coverage decision to a *Tufts HP* Member Representative, who 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. *Tufts HP* encourages 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, a *Tufts HP* Appeals and Grievances Specialist will send an acknowledgment of receipt to you, and 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 HP*, 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 *Tufts HP* within thirty (30) calendar days of the day you requested a review of your case, *Tufts HP* may, in its discretion, issue a resolution of the appeal without reviewing some or all of your medical records.

The *Tufts HP* Benefits Committee will review appeals concerning specific exclusions and payment disputes and make determinations. The *Tufts HP* 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 HP*. The time limits of this process will be waived or extended by a mutual written agreement between you or your authorized representative and *Tufts HP*.

The Appeals and Grievances Specialist will notify you in writing of *Tufts HP's* 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 representative and *Tufts HP.* 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 HP maintains records of each inquiry made by a *Member* or by that *Member's* authorized representative.

Expedited Appeals

Tufts HP recognizes that there are urgent circumstances that require a quicker turnaround than the thirty (30) calendar days allotted for the standard appeals process. *Tufts HP* 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 director 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 director 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 *Tufts HP's* receipt of the request. If your appeal meets the guidelines for an expedited appeal, you may also file a request for a simultaneous external review as described below.

External Review

For appeals involving medical necessity determinations (adverse determinations) and benefit reviews where medical judgment was used, if you do not agree with the Appeals decision, 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
Appeals & Grievances Department
705 Mt. Auburn Street
Watertown, MA 02472-9193
(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.

If you have questions

If you have questions or need help submitting a grievance or an appeal, please call a *Tufts HP* Member Representative at 1-800-462-0224 for assistance.

Bills from *Providers*

Bills from *Providers*

Medical Expenses

Occasionally, you may receive a bill from a *Provider* for *Covered Services*. Before paying the bill, contact the *Tufts HP* Member Services Department.

If you do pay the bill, you must send the following information to the Member Reimbursement Medical Claims Department:

- a completed, signed Member Reimbursement Medical Claim Form, which can be obtained from the *Tufts HP* website or by contacting the *Tufts HP* Member Services Department; and
- the documents listed on the Member Reimbursement Medical Claim Form that are required for proof of service and payment.

The address for the Member Reimbursement Medical Claims Department is listed on the Member Reimbursement Medical Claim Form.

Please note: You must contact Tufts Health *Plan* regarding your bill(s) or send your bill(s) to *Tufts HP* within twelve months from the date of service. If you do not, the bill(s) cannot be considered for payment. Most completed reimbursement requests are processed within 4-6 weeks. Incomplete requests and requests for services rendered outside of the United States may take longer. (Under this *Plan*, only *Emergency* Care services are covered outside of the United States may take longer. Reimbursements will be sent to the *Subscriber* at the address *Tufts HP* has on file. See Chapter 3 for more information.)

If you receive *Covered Services* from a non-*Tufts HP Provider*, you will be reimbursed up to the *Reasonable Charge* for the services.

The *Plan* reserves the right to be reimbursed by the *Member* for payments made in error.

Pharmacy Expenses

If you obtain a prescription from a non-designated pharmacy, you will need to pay for the prescription up front and submit a claim for reimbursement. Pharmacy claim forms can be obtained by contacting a *Member* Representative or through our website.

Limitation on Actions

Limitation on Actions

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

Chapter 6

Other *Plan* Provisions

Subrogation

The Plan's right of subrogation

You may have a legal right to recover some or all of the costs of your health care from someone else (a "Third Party"). "Third Party" means any person or company that is, could be, or is claimed to be responsible for the costs of injuries or illness to you. This includes such costs to any *Dependent* covered under this plan.

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

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

We have the right to recover those costs in your name. We can do this with or without your consent, directly from that person or company. Our right has priority, except as otherwise provided by law. We can recover against the total amount of any recovery, regardless of whether

- all or part of the recovery is for medical expenses, or
- the recovery is less than the amount needed to reimburse you fully for the illness or injury.

Personal Injury Protection/Med Pay Benefits

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

Workers' compensation

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

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

If *Tufts HP* pays for the costs of health care services or medications for any work-related illness or injury, *Tufts HP* 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 *Tufts HP* for any work-related illness or injury, please contact the *Tufts HP* Member Services Department.

The Plan's right of reimbursement

This provision applies in addition to the rights described above. You may recover money by suit, settlement, or otherwise. If this happens, you are required to reimburse *Tufts HP* for the cost of health care services, supplies, medications, and expenses for which *Tufts HP* paid or will pay.

This right of reimbursement attaches when we have provided health care benefits for expenses where a Third Party is responsible and you have recovered any amounts from any sources. This includes, but is not limited to:

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

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

Assignment of benefits

You hereby assign to the *Plan* any benefits you may be entitled to receive from a person or company that caused or is legally responsible to reimburse you for your illness or injury. Your assignment is up to the cost of health care services and supplies, and expenses that the *Plan* paid or will pay for your illness or injury.

Subrogation, continued

Member cooperation

You further agree:

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

Subrogation Agent

Tufts HP may contract with a third party to administer subrogation recoveries. In such case, that subcontractor will act as an agent for the *Tufts HP*.

Constructive Trust

By accepting benefits from the *Plan* (whether the payment of such benefits is made to you directly or made on your behalf, for example, to a *Provider)*, you hereby agree that if you receive any payment from any responsible party as a result of an injury, illness, or condition, you will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the Plan.

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. The *Plan* will coordinate benefits payable for *Covered Services* with benefits payable by other plans, consistent with state law.

Note: The *Plan* will coordinate benefits with Medicare according to federal law, rather than 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.

Tufts HP 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 member application about other health coverage you have.

After you enroll, you must notify the City of new coverage or termination of other coverage. *Tufts HP* 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, contact the *Tufts HP* Liability and Recovery Department at 1-888-880-8699, x. 21098. You can also call a Member Representative at 1-800-462-0224 and have your call transferred to the *Tufts HP* Liability and Recovery Department.

Use and Disclosure of Medical Information

Use and disclosure of medical information

For information about how *Tufts HP* uses and discloses your medical information, please contact a Member Representative at 1-800-462-0224. Information is also available on *Tufts HP*'s website.

For information about how your employer uses and discloses your medical information, please contact your employer.

Relationships between *Tufts HP* and *Providers*

Tufts HP* and *Providers

Tufts HP is an administrator of health care services. *Tufts HP* does not provide health care services. *Providers* are independent. They are not *Tufts HP* employees, agents or representatives. *Providers* are not authorized to:

- change this *Description of Benefits*; or
- assume or create any obligation for *Tufts HP*.

Tufts HP is not liable for acts, omissions, representations or other conduct of any *Provider.*

Circumstances Beyond *Tufts Health Plan*'s Reasonable Control

Circum-stances beyond *Tufts HP*'s reasonable control	*Tufts Health Plan* shall not be responsible for a failure or delay in arranging for the provision of services in cases of circumstances beyond the reasonable control of *Tufts HP*. Such circumstances include, but are not limited to: major disaster; epidemic; strike; war; riot; and civil insurrection. In such circumstances, *Tufts HP* will make a good faith effort to arrange for the provision of services. In doing so, *Tufts HP* will take into account the impact of the event and the availability of *Tufts HP Providers.*

Group Contract

Acceptance of the Terms of the Plan	By signing and returning the member application form, individuals apply for coverage under the *Plan* and agree to all the terms and conditions of the *Plan* and this *Description of Benefits*.
Payments for coverage	The *Plan* under which you are covered is a self-funded plan. This means that the City is responsible for funding *Covered Services* for *Members* in accordance with the terms of the Plan. Under an administrative services agreement between the City and *Tufts HP*, *Tufts HP* processes claims, disburses *Plan* funds and provides other services only when the City has forwarded adequate funds to *Tufts HP* in a timely manner. *Tufts HP* is not responsible if the City fails to provide funds to *Tufts HP* to pay for *Covered Services*. This is the case if the City has charged the *Member* for some or all of the cost of coverage under the Plan. If the City fails to provide adequate funds for claims payment, *Tufts HP* has no responsibility to pay claims.

Changes to this *Description of Benefits*

The City may revise the *Plan* and this *Description of Benefits* in accordance with the terms of the Plan. Revisions do not require the consent of *Members*. Notice of revisions will be sent to *Members* and will include the *Effective Date* of the revision. The City is responsible for notifying *Members* of revisions. *Tufts HP* is not responsible if the City 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 *Tufts HP* sends a notice to you, it will be sent to your last address on file with *Tufts HP*.

Notice to *Tufts HP*: *Members* should address all correspondence to: *Tufts Health Plan*, Member Services, P.O. Box 9173, Watertown, MA 02472-9166.

Enforcement of terms

Tufts HP may choose to waive certain terms of the Group Contract, if applicable, including the Description of Benefits. This does not mean that Tufts HP gives 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 July 1, 2021 and supersedes all previous Descriptions of Benefits.

Appendix A

Glossary of Terms

Terms and Definitions

Term/ definition table The table below defines the terms used in this *Description of Benefits*.

Term	Definition
Benefit Period	The way that Medicare measures your use of hospital and *Skilled* nursing facility services. A *Benefit Period* begins the day you go to a hospital or *Skilled* nursing facility. The *Benefit Period* ends when you have not received 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.
The City	The City of Newton which sponsors the *Plan* and contracts with *Tufts HP* for the provision of certain services. Also referred to as "City of Newton."
Coinsurance	The percentage of costs you must pay for certain *Covered Services*.
Copayment	Fees you pay for *Covered Services*. Copayments are paid to the *Provider* when you receive care unless the *Provider* arranges otherwise.
Cost Sharing Amount	The cost you pay for certain *Covered Services*. This amount may consist of *Deductibles*, *Copayments*, and/or *Coinsurance*.
Covered Services	The services and supplies for which the *Plan* will pay. They must be • described in Chapter 3 of this *Description of Benefits* (subject to the "Exclusions from Benefits" section in Chapter 3) or in the Medicare Handbook; and • *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.

Terms and Definitions, continued

Term	Definition
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 behavioral health 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, when no other aspects of treatment require an acute hospital level of care. Note: *Custodial Care* is not covered by the *Plan*.
Day Surgery	Any surgical procedure(s) provided to a *Member* at a facility licensed by the state to perform surgery, and with an expected departure the same day, or in some instances, within twenty-four hours. Also referred to as "Ambulatory Surgery" or "Surgical Day Care."
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 health benefits under this Plan.
Developmental	Refers to a delay in the expected achievement of age-appropriate fine motor, gross motor, social, or language milestones that is not caused by an underlying medical illness or conditions.

Terms and Definitions, continued

Term	Definition
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	The date, according to the *Plan's* records, when you become a Member and are first eligible for *Covered Services*.
Emergency	An illness or medical condition, whether physical or mental, that manifests itself by symptoms of sufficient severity, including severe pain, such 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); or • 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.

Terms and Definitions, continued

Term	Definition
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; • even if approved for lawful marketing by the U.S. Food and Drug Administration, reliable scientific evidence does not support that the treatment is 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; or • there is no scientific or clinical evidence that the treatment is at least as beneficial as any established, evidence-based alternatives. This definition is fully explained in the corresponding Medical Necessity Guidelines.

Term	Definition
Individual Coverage	Coverage for a *Subscriber* 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	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 service 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 HP* uses Medical Necessity coverage guidelines which are: • developed with input from practicing physicians in the *Tufts HP* Service Area; • 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 • scientific evidence-based, if practicable.
Member	A *Subscriber* who is covered under the *Plan* and therefore entitled to all *Covered Services* 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.

Terms and Definitions, continued

Term	Definition
Non-Conventional Medicine	A group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine and are generally not based on scientific evidence. Since these services are not based on scientific evidence, they do not meet the *Tufts Health Plan* definition of *Medical Necessity* and are not covered. Providers of these non-covered services may be contracting or non-contracting traditional medical providers. These services may be offered in connection with a traditional office visit. Providers of *Non-Convention Medicine* services often request payment up front because health insurance typically does not cover these services. Common terminology used to refer to these types of services include, but are not limited to, "alternative medicine", "complementary medicine", "integrative medicine", "functional health medicine", and may be described as treating "the whole person", "the entire individual", or "the inner self", and may refer to re-balancing hormones or finding underlying causes that lead to bodily dysfunction. Examples of *Non-Conventional Medicine* and related services include, but are not limited to: • holistic, naturopathic, energy medicine (e.g., Reiki, Ayurvedic, magnetic fields); • manipulative and body-based practices (e.g., reflexology, yoga, exercise therapy, tai-chi); • mind-body medicine (e.g., hypnotherapy, meditation, stress management); • whole medicine systems (e.g., naturopathy, homeopathy); • biologically based practices (e.g., herbal medicine, dietary supplements, probiotics); and • other related practices when provided in connection with *Non-Conventional Medicine* services (e.g., animal therapy, art therapy, dance therapy, sleep therapy, light therapy, energy-balancing, breathing exercises).
Observation	The use of hospital services to treat and/or evaluate a condition that should result in either a discharge within forty-eight (48) hours or a verified diagnosis and concurrent treatment plan. At times, an *Observation* stay may be followed by an *Inpatient* admission to treat a diagnosis revealed during the period of *Observation.*
Open Enrollment Period	The period of time each year when *Members* are allowed to apply for or change coverage under the *Plan*.

Terms and Definitions, continued

Term	Definition
Outpatient	A patient who receives care other than on an *Inpatient* basis. This includes services provided in: • a physician's office; • a *Day Surgery* or ambulatory care unit; and • an emergency room or *Outpatient* clinic.
Plan	The benefits plan established and maintained by the City. This *Description of Benefits* describes the only health benefit option under the Plan.
Plan Administrator	The person(s) or entity designated by the *Plan* as the *Plan Administrator* or, if not so designated, the employer.
Plan Effective Date	The date upon which *Tufts HP* first began provided services.

Terms and Definitions, continued

Term	Definition
Plan Year	The 12 month period designated by the employer. See *Plan* Information for the *Plan Year* period applicable to the *Plan*.
Provider	A health care professional or facility licensed in accordance with applicable state law, including, but not limited to, hospitals, limited service medical clinics (if available),*Urgent Care Centers* (if available) physicians, certified nurse midwives, certified registered nurse anesthetists, nurse practitioners, optometrists, podiatrists, psychiatrists, psychologists, licensed mental health counselors, licensed independent clinical social workers, licensed psychiatric nurses who are certified as clinical specialists in psychiatric and mental health nursing, licensed speech-language pathologists, and licensed audiologists. 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. within the scope of the *Provider's* license. Notes: • with respect to *Outpatient* services for the treatment of alcoholism, *Provider* means an accredited or licensed hospital or any public or private facility or portion of that facility providing services especially for the rehabilitation of intoxicated persons or alcoholics and which is licensed by the Massachusetts Department of Public Health or under other applicable state law. • with respect to *Inpatient* Services for the treatment of alcoholism, *Provider* means: an accredited or licensed hospital or any public or private facility or portion of that facility providing services especially for the detoxification or rehabilitation of intoxicated persons or alcoholics and which is licensed by the Massachusetts Department of Public Health; or a residential alcohol treatment program, as defined under Massachusetts law or other applicable state law.
Reasonable Charge	The lesser of the: • amount charged; or • amount that *Tufts HP* determines, based upon nationally accepted means of claims payment and the fees most often charged by similar *Providers* for the same service in the geographic area in which it is given, to be the reasonable amount for the service. Nationally accepted means of claims payment includes, but is not limited to: CMS medical coding policies, AMA CPT coding guidelines, nationally recognized academy and society coding and clinical guidelines.

Terms and Definitions, continued

Term	Definition
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.
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.
Subscriber	An individual who is (a) eligible for and enrolled in Medicare Parts A and B, (b) was formerly employed by the City, and (c) meets the eligibility requirements as determined by the City; this shall also mean an active employee who is eligible for and actively enrolled in Medicare Parts A and B.
Tufts Health Plan or Tufts HP	Total Health Plan, Inc. ("THP"), a Massachusetts corporation d/b/a *Tufts Health Plan*. THP enters into arrangements with Groups or payors underwriting health benefit plans to make available a network of preferred *Providers* and to provide certain services to the health benefit plans including, but not limited to, processing claims for benefits and enrollment. THP is not the *Plan Administrator* and does not insure the *Plan*. Also referred to as "*Tufts HP*".
Urgent Care	Care provided when your health is not in serious danger, but you need immediate medical attention for an unforeseen illness or injury. Examples of illnesses or injuries in which *Urgent Care* might be needed are a broken or dislocated toe, a cut that needs stitches but is not actively bleeding, sudden extreme anxiety, or symptoms of a urinary tract infection. Note: Care that is rendered after the *Urgent* condition has been treated and stabilized and the *Member* is safe for transport is not considered *Urgent Care*.

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Tufts Health Plan is committed to safeguarding the privacy of our members' protected health information ("PHI"). PHI is information which:

- identifies you (or can reasonably be used to identify you); and
- relates to your physical or mental/behavioral health or condition, the provision of health care to you or the payment for that care.

We are required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to your PHI. This Notice of Privacy Practices describes how we may collect, use, and disclose your PHI, and your rights concerning your PHI. This Notice applies to all members of Tufts Health Plan's insured health benefit plans (including HMO plans; Tufts Health Plan Medicare Preferred plans; and insured POS and PPO plans. It also applies to all members of health plans insured by Tufts Insurance Company (a Tufts Health Plan affiliate). It does not apply to products offered by Tufts Health Public Plans. Unless your employer has notified you otherwise, this Notice of Privacy Practices also applies to all members of self-insured group health plans that are administered by a Tufts Health Plan entity.

How We Obtain PHI

As a managed care plan, we engage in routine activities that result in our being given PHI from sources other than you. For example, health care providers – such as physicians and hospitals – submit claim forms containing PHI to enable us to pay them for the covered health care services they have provided to you.

NOTICE OF PRIVACY PRACTICES, continued

How We Use and Disclose Your PHI

We use and disclose PHI in a number of ways to carry out our responsibilities as a managed care plan. The following describes the types of uses and disclosures of PHI that federal law permits us to make without your specific authorization:

- **Treatment:** We may use and disclose your PHI to health care providers to help them treat you. For example, our care managers may disclose PHI to a home health care agency to make sure you get the services you need after discharge from a hospital.

- **Payment Purposes:** We use and disclose your PHI for payment purposes, such as paying doctors and hospitals for covered services. Payment purposes also include activities such as: determining eligibility for benefits; reviewing services for medical necessity; performing utilization review; obtaining premiums; coordinating benefits; subrogation; and collection activities.

- **Health Care Operations:** We use and disclose your PHI for health care operations. For example, this includes: population-based activities relating to improving health or reducing health care costs; coordinating/managing care; assessing and improving the quality of health care services; reviewing the qualifications and performance of providers; reviewing health plan performance; conducting medical reviews; and resolving grievances. It also includes business activities such as: underwriting; rating; placing or replacing coverage; determining coverage policies; business planning; obtaining reinsurance; arranging for legal and auditing services (including fraud and abuse detection programs); and obtaining accreditations and licenses. We do not use or disclose PHI that is genetic information for underwriting purposes.

- **Health and Wellness Information:** We may use or disclose your PHI so that you may be contacted you with information about: appointment reminders; treatment alternatives; therapies; health care providers; settings of care; or other health-related benefits, services and products that may be of interest to you. For example, you may receive information about smoking cessation programs, or we might send a mailing to subscribers approaching Medicare eligible age with materials describing our senior products and an application form.

- **Organizations That Assist Us:** In connection with treatment, payment and health care operations, we may share your PHI with our affiliates and third party “business associates” that perform activities for us or on our behalf, for example, our pharmacy benefit manager. We will obtain assurances from our business associates that they will appropriately safeguard your information.

NOTICE OF PRIVACY PRACTICES, continued

How We Use and Disclose Your PHI – continued

- **Plan Sponsors:** If you are enrolled in Tufts Health Plan through your current or former place of work, you are enrolled in a group health plan. We may disclose PHI to the group health plan's plan sponsor – usually your employer – for plan administration purposes. A plan sponsor of an insured health benefit plan must certify that it will protect the PHI in accordance with law.

- **Public Health and Safety; Health Oversight:** We may disclose your PHI: to a public health authority for public health activities, such as responding to public health investigations; when authorized by law, to appropriate authorities, if we reasonably believe you are a victim of abuse, neglect or domestic violence; when we believe in good faith that it is necessary to prevent or lessen a serious and imminent threat to your or others' health or safety; or to health oversight agencies for certain activities such as: audits; disciplinary actions; and licensure activity.

- **Legal Process; Law Enforcement; Specialized Government Activities:** We may disclose your PHI in the course of legal proceedings; in certain cases, in response to a subpoena, discovery request or other lawful process; to law enforcement officials for such purposes as responding to a warrant or subpoena; or for specialized governmental activities such as national security.

- **Research; Death; Organ Donation:** We may disclose your PHI to researchers, provided that certain established measures are taken to protect your privacy. We may disclose PHI, in certain instances, to coroners, medical examiners and in connection with organ donation.

- **Workers' Compensation:** We may disclose your PHI when authorized by workers' compensation laws.

- **Family and Friends:** We may disclose PHI to a family member, relative, or friend – or anyone else you identify – as follows: (i) when you are present prior to the use or disclosure and you agree; or (ii) when you are not present (or you are incapacitated or in an emergency situation) if, in the exercise of our professional judgment and in our experience with common practice, we determine that the disclosure is in your best interests. In these cases, we will only disclose the PHI that is directly relevant to the person's involvement in your health care or payment related to your health care.

- **Personal Representatives:** Unless prohibited by law, we may disclose your PHI to your personal representative, if any. A personal representative is a person who has legal authority to act on your behalf regarding your health care or health care benefits. For example, an individual named in a durable power of attorney, or a parent or guardian of an unemancipated minor, are personal representatives.

NOTICE OF PRIVACY PRACTICES, continued

How We Use and Disclose Your PHI – continued

- **Communications:** We will communicate information containing your PHI to the address or telephone number we have on record for the subscriber of your health benefits plan. Also, we may mail information containing your PHI to the subscriber. For example, communication regarding member requests for reimbursement may be addressed to the subscriber. We will not make separate mailings for enrolled dependents at different addresses, unless we are requested to do so and agree to the request. See below "Right to Receive Confidential Communications: for more information on how to make such a request.

- **Required by Law:** We may use or disclose your PHI when we are required to do so by law. For example, we must disclose your PHI to the U.S. Department of Health and Human Services upon request if they wish to determine whether we are in compliance with federal privacy laws.

If one of the above reasons does not apply, we will not use or disclose your PHI without your written permission ("authorization"). You may give us written authorization to use or disclose your PHI to anyone for any purpose. You may later change your mind and revoke your authorization in writing. However, your written revocation will not affect actions we've already taken in reliance on your authorization. Where state or other federal laws offer you greater privacy protections, we will follow those more stringent requirements. For example, under certain circumstances, records that contain information about: alcohol abuse treatment; drug abuse prevention or treatment; AIDS-related testing or treatment; or certain privileged communications, may not be disclosed without your written authorization. In addition, when applicable, we must have your written authorization before using or disclosing medical or treatment information for a member appeal. See below "Who to Contact for Questions or Complaints" if you would like more information.

NOTICE OF PRIVACY PRACTICES, continued

How We Protect PHI Within Our Organization

Tufts Health Plan protects oral, written and electronic PHI throughout our organization. We do not sell PHI to anyone. We have many internal policies and procedures designed to control and protect the internal security of your PHI. These policies and procedures address, for example, use of PHI by our employees. In addition, we train all employees about these policies and procedures. Our policies and procedures are evaluated and updated for compliance with applicable laws.

Your Individual Rights

The following is a summary of your rights with respect to your PHI:

- **Right of Access to PHI:** You have the right to inspect and get a copy of most PHI Tufts Health Plan has about you, or a summary explanation of PHI if agreed to in advance by you. Requests must be made in writing and reasonably describe the information you would like to inspect or copy. If your PHI is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable cost-based fee for paper or electronic copies as established by state or federal law. Under certain circumstances, we may deny your request. If we do so, we will send you a written notice of denial describing the basis of our denial. You may request that we send a copy of your PHI directly to another person that you designate. Your request must be in writing, signed by you, and clearly identify the person and the address where the PHI should be sent.

- **Right to Request Restrictions:** You have the right to ask that we restrict uses or disclosures of your PHI to carry out treatment, payment and health care operations, and disclosures to family members or friends. We will consider the request. However, we are not required to agree to it and, in certain cases, federal law does not permit a restriction. Requests may be made verbally or in writing to Tufts Health Plan.

- **Right to Receive Confidential Communications:** You have the right to ask us to send communications of your PHI to you at an address of your choice or that we communicate with you in a certain way. For example, you may ask us to mail your information to an address other than the subscriber's address. We will accommodate your request if: you state that disclosure of your PHI through our usual means could endanger you; your request is reasonable; it specifies the alternative means or location; and it contains information as to how payment, if any, will be handled. Requests may be made verbally or in writing to Tufts Health Plan.

- **Right to Amend PHI:** You have the right to have us amend most PHI we have about you. We may deny your request under certain circumstances. If we deny your request, we will send you a written notice of denial. This notice will describe the reason for our denial and your right to submit a written statement disagreeing with the denial. Requests must be in writing to Tufts Health Plan and must include a reason to support the requested amendment.

NOTICE OF PRIVACY PRACTICES, continued

- **Right to Receive an Accounting of Disclosures:** You have the right to a written accounting of the disclosures of your PHI that we made in the last six years prior to the date you request the accounting. However, except as otherwise provided by law, this right does not apply to: (i) disclosures we made for treatment, payment or health care operations; (ii) disclosures made to you or people you have designated; (iii) disclosures you or your personal representative have authorized; (iv) disclosures made before April 14, 2003; and (v) certain other disclosures, such as disclosures for national security purposes. IF you request an accounting more than once in a 12-month period, we may charge you a reasonable fee. All requests for an accounting of disclosures must be made in writing to Tufts Health Plan.

- **Right to authorize other use and disclosure:** You have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization at any time, in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.

- **Right to receive a privacy breach notice:** You have the right to receive written notification if we discover a breach of your unsecured PHI and determine through a risk assessment that notification is required.

- **Right to this notice:** You have a right to receive a paper copy of this Notice from us on request.

NOTICE OF PRIVACY PRACTICES, continued

Your Individual Rights – continued

- **How to Exercise Your Rights:** To exercise any of the individual rights described above or for more information, please call a Member Representative at 1-800-462-0224 (TDD: 711) or write to:

  Compliance Department
  Tufts Health Plan
  705 Mount Auburn Street
  Watertown, MA 02472-1508

Effective Date of Notice

This Notice takes effect October 1, 2015. We must follow the privacy practices described in this Notice while it is in effect. This Notice will remain in effect until we change it. This Notice replaces any other information you have previously received from us with respect to privacy of your medical information.

Changes to this Notice of Privacy Practices

We may change the terms of this Notice at any time in the future and make the new Notice effective for all PHI that we maintain – whether created or received before or after the effective date for the new Notice. Whenever we make an important change, we will publish the updated Notice on our website. In addition, we will use one of our periodic mailings to inform subscribers about the updated Notice.

Who to Contact for Questions or Complaints

If you would like more information or a paper copy of this Notice, please contact a Member Representative at the number listed above. You can also download a copy form our website. If you believe your privacy rights may have been violated, you have a right to complain to Tufts Health Plan by calling the Privacy Officer at 1-800-208-9549 or writing to:

Privacy Officer
Compliance Department
Tufts Health Plan
705 Mount Auburn Street
Watertown, MA 02472-1508

You also have a right to complain to the Secretary of Health and Human Services. We will not retaliate against you for filing a complaint.

Tufts Associated Health Maintenance Organization, Inc., Total Health Plan, Inc., Tufts Benefit Administrators, Inc., and Tufts Insurance Company do business as Tufts Health Plan. Tufts Health Plan is a registered trademark of Tufts Associated Health Maintenance Organization, Inc.

ANTI-DISCRIMINATION NOTICE

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

Tufts Health Plan:

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

If you need these services, contact Member Services.

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

Tufts Health Plan
Attention: Civil Rights Coordinator Legal Dept.
705 Mount Auburn St. Watertown, MA 02472
Phone: 888.880.8699 ext. 48000, TTY number — 800.439.2370 or 711
Fax: 617.972.9048
Email: OCRCoordinator@tufts-health.com

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

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201
800.368.1019, 800.537.7697 (TDD)

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

tuftshealthplan.com | 800.462.0224