January 1 – December 31, 2024

Evidence of Coverage:

Your Medicare and MassHealth (Medicaid) Health Benefits and Services and Prescription Drug Coverage as a Member of Tufts Health Plan Senior Care Options (HMO SNP) or Tufts Health Plan Senior Care Options CW (HMO SNP)

This document gives you the details about your Medicare and MassHealth (Medicaid) health care and prescription drug coverage from January 1 – December 31, 2024. **This is an important legal document. Please keep it in a safe place.**

For questions about this document, please contact Member Services at 1-855-670-5934. (TTY users should call 711). Hours are 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31, and Monday - Friday from April 1 to September 30. This call is free.

This plan, Tufts Health Plan Senior Care Options or Tufts Health Plan Senior Care Options CW, is offered by Tufts Health Plan. (When this *Evidence of Coverage* says "we," "us," or "our," it means Tufts Health Plan. When it says "plan" or "our plan," it means Tufts Health Plan Senior Care Options and Tufts Health Plan Senior Care Options CW, collectively referred to as Tufts Health Plan Senior Care Options in the rest of this document, except where otherwise noted.)

This document is available for free in Spanish and other languages.

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

Benefits, premiums, deductibles, and/or copayments/coinsurance may change on January 1, 2025. Because you get assistance from MassHealth (Medicaid), you have no cost-share for covered services.

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

Tufts Health Plan Senior Care Options is an HMO-SNP plan with a Medicare contract and a contract with the Commonwealth of Massachusetts MassHealth (Medicaid) program. Enrollment in Tufts Health Plan Senior Care Options depends on contract renewal. The plan also has a written agreement with the Massachusetts Medicaid program to coordinate your MassHealth (Medicaid) benefits.

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

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

2024 Evidence of Coverage

Table of Contents

CHAPTER 1:
Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in Tufts Health Plan Senior Care Options, which is a specialized Medicare Advantage Plan (Special Needs Plan)

You are covered by both Medicare and MassHealth (Medicaid):

- **Medicare** is the Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (kidney failure).
- **MassHealth (Medicaid)** is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. MassHealth (Medicaid) coverage varies depending on the type of MassHealth (Medicaid) you have. Some people with MassHealth (Medicaid) get help paying for their Medicare premiums and other costs. Other people also get coverage for additional services and drugs that are not covered by Medicare.

You have chosen to get your Medicare and MassHealth (Medicaid) health care and your prescription drug coverage through our plan, Tufts Health Plan Senior Care Options. We are required to cover all Part A and Part B services. However, cost sharing and provider access in this plan differ from Original Medicare.

Tufts Health Plan Senior Care Options is a specialized Medicare Advantage Plan (a Medicare Special Needs Plan), which means its benefits are designed for people with special health care needs. Tufts Health Plan Senior Care Options is designed for people who have Medicare and who are also entitled to assistance from Medicaid.

Because you get assistance from MassHealth (Medicaid) with your Medicare Part A and B cost sharing (deductibles, copayments, and coinsurance) you may pay nothing for your Medicare health care services. MassHealth (Medicaid) also provides other benefits to you by covering health care services that are not usually covered under Medicare. You will also receive "Extra Help" from Medicare to pay for the costs of your Medicare prescription drugs. Tufts Health Plan Senior Care Options will help manage all of these benefits for you, so that you get the health care services and payment assistance that you are entitled to.

Tufts Health Plan Senior Care Options is run by a non-profit organization. Like all Medicare Advantage Plans, this Medicare Special Needs Plan is approved by Medicare. The plan also has a contract with the Massachusetts MassHealth (Medicaid) program to coordinate your MassHealth (Medicaid) benefits. We are pleased to be providing your Medicare and MassHealth (Medicaid) health care coverage, including your prescription drug coverage.

Coverage under this Plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility

requirement. Please visit the Internal Revenue Service (IRS) website at: www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

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

This *Evidence of Coverage* document tells you how to get your Medicare and MassHealth (Medicaid) medical care, long-term care and/or home and community-based services, and prescription drugs. It explains your rights and responsibilities, what is covered, what you pay as a member of the plan, and how to file a complaint if you are not satisfied with a decision or treatment.

The words coverage and covered services refer to the medical care, long-term care and/or home and community-based services, and services and the prescription drugs available to you as a member of Tufts Health Plan Senior Care Options.

It's important for you to learn what the plan's rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* document.

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

Section 1.3 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how Tufts Health Plan Senior Care Options covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs (Formulary)*, and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called riders or amendments.

The contract is in effect for months in which you are enrolled in Tufts Health Plan Senior Care Options between January 1, 2024 and December 31, 2024.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of Tufts Health Plan Senior Care Options after December 31, 2024. We can also choose to stop offering the plan in your service area, or to offer it in a different service area, after December 31, 2024. Because you get assistance from MassHealth (Medicaid), you will have no cost-shares for covered services.

Medicare (the Centers for Medicare & Medicaid Services) and the Commonwealth of Massachusetts must approve Tufts Health Plan Senior Care Options each year. You can continue each year to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and both Medicare and the Commonwealth of Massachusetts renew their approvals of the plan.

SECTION 2 What makes you eligible to be a plan member?

Section 2.1 Enrollment in Tufts Health Plan Senior Care Options

You must be enrolled in Tufts Health Plan Senior Care Options to be a plan member.

- Tufts Health Plan accepts and processes applications in the order in which they are received, regardless of your income status, physical or behavioral condition, age, gender, gender identity, sexual orientation, religion, creed, race, color, physical or behavioral disability, national origin, ancestry, pre-existing condition(s), health status or expected health status, or need for health care services, in accordance with Federal and State requirements.
- Tufts Health Plan will assess your care level and, if necessary, submit a Minimum Data Set-Home Care (MDS-HC) to the State Executive Office of Health and Human Services (EOHHS) within 30 days of your effective date
- Enrollment requests that are submitted to Tufts Health Plan by eligible beneficiaries by the last business day of the month are processed by and effective on the first calendar day of the following month.
- Tufts Health Plan is responsible for providing covered services to you from your effective date of enrollment.
- If your enrollment request is denied, you have the right to ask us to reconsider this decision through the grievance process described in Chapter 8 of this Evidence of Coverage.

Section 2.2 Your eligibility requirements

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

- You have both Medicare Part A and Medicare Part B
- -- *and* -- You live in our geographic service area (Section 2.4 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.
- -- *and* -- you are a United States citizen or are lawfully present in the United States
- -- *and* -- You meet the special eligibility requirements described below.

Special eligibility requirements for our plan

Our plan is designed to meet the needs of people who receive certain MassHealth (Medicaid) benefits. MassHealth (Medicaid) is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources.) To be eligible for our plan you must be:

- Aged 65 or older
- Enrolled in MassHealth Standard (Medicaid)
- Residing in our geographic service area (section 2.4 describes our service area)
- Not have any other comprehensive health insurance, except Medicare
- Living at home or in a long-term-care facility (You cannot be an inpatient at a chronic or rehabilitation hospital or reside in an intermediate care facility for people with intellectual disabilities.)

You may also qualify if you are eligible for the Frail Elder Waiver (FEW). For information about the FEW program, contact Aging Services Access Points (ASAPs) at 1-800-243-4636 TTY: 1-800-439-2370.

Please note: If you lose your eligibility but can reasonably be expected to regain eligibility within **one**-month(s), then you are still eligible for membership in our plan (Chapter 4, Section 2.1 tells you about coverage and cost sharing during a period of deemed continued eligibility).

Section 2.3 What is MassHealth (Medicaid)?

MassHealth (Medicaid) is a joint Federal and state government program that helps with medical and long-term care costs for certain people who have limited incomes and resources. Each state decides what counts as income and resources, who is eligible, what services are covered, and the cost for services. States also can decide how to run their program as long as they follow the Federal guidelines.

In addition, there are programs offered through MassHealth (Medicaid) that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full MassHealth (Medicaid) benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full MassHealth (Medicaid) benefits (SLMB+).)

Section 2.4 Here is the plan service area for Tufts Health Plan Senior Care Options

Although Medicare is a Federal program, Tufts Health Plan Senior Care Options is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below:

Our service area includes these counties in Massachusetts.

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

If you plan to move out of the service area, you cannot remain a member of this plan. Please contact Member Services to see if we have a plan in your new area. When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

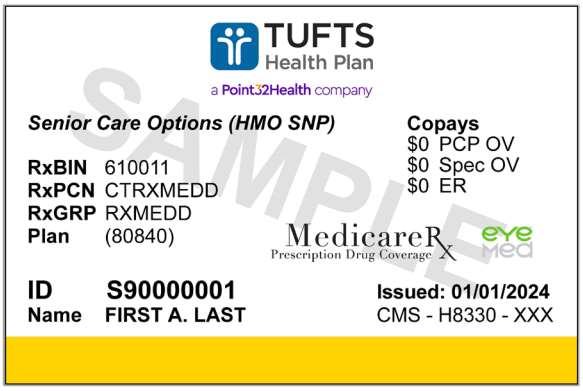
Section 2.5 U.S. Citizen or Lawful Presence

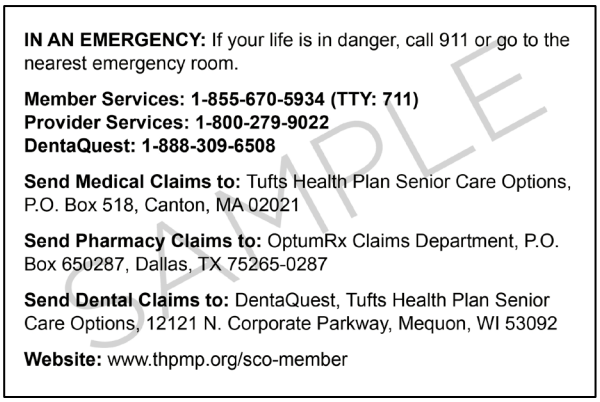
A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify Tufts Health Plan Senior Care Options if you are not eligible to remain a member on this basis. Tufts Health Plan Senior Care Options must disenroll you if you do not meet this requirement.

SECTION 3 Important membership materials you will receive

Section 3.1 Your plan membership card

While you are a member of our plan, you must use your membership card whenever you get services covered by this plan and for prescription drugs you get at network pharmacies. You should also show the provider your MassHealth (Medicaid) card. Here’s a sample membership card to show you what yours will look like:





Do NOT use your red, white, and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your Tufts Health Plan Senior Care Options membership card, you may have to pay the full cost of medical services yourself.

Note: Because you get assistance from MassHealth (Medicaid), you have no cost share for covered services when you use your membership card.

Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare approved clinical research studies also called clinical trials.

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

Section 3.2 Provider and Pharmacy Directory: Your guide to all providers and pharmacies in the plan's network

The *Provider and Pharmacy Directory* lists our current network providers, pharmacies, and durable medical equipment suppliers. All providers in the *Provider and Pharmacy Directory* accept both Medicare and MassHealth (Medicaid).

Network providers are the doctors and other health care professionals, medical groups, and durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full.
Note: Because you get assistance from MassHealth (Medicaid), you have no cost share for covered services.

You must use network providers to get your medical care and services. If you go elsewhere without proper authorization you will have to pay in full. The only exceptions are emergencies, urgently needed services when the network is not available (that is, in situations when it is unreasonable or not possible to obtain services in-network), out-of-area dialysis services, and

cases in which Tufts Health Plan Senior Care Options authorizes use of out-of-network providers.

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

Network pharmacies are all of the pharmacies that have agreed to fill covered prescriptions for our plan members. You can use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use. See Chapter 5, section 2.5 for information on when you can use pharmacies that are not in the plan's network.

If you don't have your copy of the *Provider and Pharmacy Directory*, you can request a copy (electronically or in hardcopy form) from Member Services. Requests for hardcopy Provider and Pharmacy Directory will be mailed to you within three business days. You may ask Member Services for more information about our network providers, including their qualifications. You can also see the *Provider and Pharmacy Directory* at www.thpmp.org/sco or download it from this website. Both Member Services and the website can give you the most up-to-date information about changes in our network providers or pharmacy network.

Section 3.3 The plan's *List of Covered Drugs (Formulary)*

The plan has a *List of Covered Drugs (Formulary)*. We call it the "Drug List" for short. It tells which Part D prescription drugs are covered under the Part D benefit included in Tufts Health Plan Senior Care Options. In addition to the drugs covered by Part D, some prescription drugs are covered for you under your MassHealth Standard (Medicaid) benefits. The Over-the-Counter (OTC) "Drug List" tells you how to find out which drugs are covered under MassHealth Standard (Medicaid).

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the Tufts Health Plan Senior Care Options "Drug List".

The "Drug List" also tells you if there are any rules that restrict coverage for your drugs.

We will provide you a copy of the "Drug List". To get the most complete and current information about which drugs are covered, you can visit the plan's website (www.thpmp.org/sco) or call Member Services.

SECTION 4 Your monthly costs for Tufts Health Plan Senior Care Options (Note: As a member of Tufts Health Plan Senior Care Options, you do not pay a separate monthly premium.) You do not have a cost to covered services.

Note: All references to "premiums" and "premium changes" in this Section 4 are to Medicare premiums. As a member of Tufts Health Plan Senior Care Options, your Medicare premiums are paid by MassHealth (Medicaid) and will not change.

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Part D Late Enrollment Penalty (Section 4.3)
- Income Related Monthly Adjusted Amount (Section 4.4)

Section 4.1 Plan premium

You do not pay a separate monthly plan premium for Tufts Health Plan Senior Care Options.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

Some members are required to pay other Medicare premiums. As explained in Section 2 above, in order to be eligible for our plan, you must maintain your eligibility with MassHealth (Medicaid) as well as have both Medicare Part A and Medicare Part B. For most Tufts Health Plan Senior Care Options members, MassHealth (Medicaid) pays for your Part A premium (if you don't qualify for it automatically) and for your Part B premium.

If MassHealth (Medicaid) is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain a member of the plan. This includes your premium for Part B. It may also include a premium for Part A which affects members who aren't eligible for premium free Part A.

Section 4.3 Part D Late Enrollment Penalty

Because you are dually-eligible, the LEP doesn't apply to you as long as you maintain your dually-eligible status, but if you lose your dually-eligible status, you may incur an LEP. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. Creditable prescription drug coverage is coverage that meets Medicare's minimum standards since it is

expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

You **will not** have to pay it if:

- You receive "Extra Help" from Medicare to pay for your prescription drugs.
- You have gone less than 63 days in a row without creditable coverage.
- You have had creditable drug coverage through another source such as a former employer, union, TRICARE, or Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.
    - **Note:** Any notice must state that you had creditable prescription drug coverage that is expected to pay as much as Medicare's standard prescription drug plan pays.
    - **Note:** The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.

Medicare determines the amount of the penalty. Here is how it works:

- First, count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2024 this average premium amount was $34.70.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here it would be 14% times $34.70, which equals $4.86. This rounds to $4.90. This amount would be added **to the monthly premium for someone with a Part D late enrollment penalty**.

There are three important things to note about this monthly Part D late enrollment penalty:

- First, **the penalty may change each year**, because the average monthly premium can change each year.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.

- Third, if you are under 65 and currently receiving Medicare benefits, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review. Generally, you must request this review **within 60 days** from the date on the first letter you receive stating you have to pay a late enrollment penalty. However, if you were paying a penalty before joining our plan, you may not have another chance to request a review of that late enrollment penalty.

Important: Do not stop paying your Part D late enrollment penalty while you're waiting for a review of the decision about your late enrollment penalty. If you do, you could be disenrolled for failure to pay your plan premiums.

Section 4.4 Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA. The extra charge is figured out using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans.

If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. **You must pay the extra amount to the government. It cannot be paid with your monthly plan premium. If you do not pay the extra amount you will be disenrolled from the plan and lose prescription drug coverage.**

If you disagree about paying an extra amount, you can ask Social Security to review the decision. To find out more about how to do this, contact Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

SECTION 5 More information about your monthly premium – There is no separate SCO premium other than Medicare

Section 5.1 Can we change your monthly plan premium during the year?

No. We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year we will tell you in September and the change will take effect on January 1.

However, in some cases, you may be able to stop paying a late enrollment penalty, if owed. Or need to start paying a late enrollment penalty. (This could happen if you become eligible for the "Extra Help" program or if you lose your eligibility for the "Extra Help" program during the year:

- If you currently pay the Part D late enrollment penalty and become eligible for "Extra Help" during the year, you would be able to stop paying your penalty.
- If you lose Extra Help, you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable prescription drug coverage.

You can find out more about the "Extra Help" program in Chapter 2, Section 7.

SECTION 6 Keeping your plan membership record up to date

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

The doctors, hospitals, pharmacists, and other providers in the plan's network need to have correct information about you. **These network providers use your membership record to know what services and drugs are covered and the cost-sharing amounts for you**. Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse or domestic partner's employer, workers' compensation, or MassHealth Standard (Medicaid)) Please note that to be eligible for Tufts Health Plan Senior Care Options, you cannot have any comprehensive health insurance other than Medicare.
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If you receive care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes

- If you are participating in a clinical research study (**Note:** You are not required to tell your plan about the clinical research studies you intend to participate in but we encourage you to do so.)

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

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

All changes that affect eligibility must also be reported to MassHealth (Medicaid) within 10 days, or earlier, if possible.

If you have changes to report, please contact MassHealth (Medicaid) through one of the following methods:

- Call MassHealth (Medicaid) at 1-800-841-2900 (TTY 711)
- Fax MassHealth (Medicaid) at 1-857-323-8300
- Or notify MassHealth (Medicaid) by mail at:
  Health Insurance Processing Center
  P.O. Box 4405
  Taunton, MA 02780.

SECTION 7 How other insurance works with our plan

Other insurance

Note: This section may not apply to you because enrollment in the Tufts Health Plan Senior Care Options is restricted to members who do not have any other comprehensive health insurance, except Medicare.

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. This is called **Coordination of Benefits**.

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Member Services. You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the primary payer and pays up to the limits of its coverage. The one that pays second, called the secondary payer, only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs. If you have other insurance, tell your doctor, hospital, and pharmacy.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
    - If you're under 65 and disabled and you or your family member is still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
    - If you're over 65 and you or your spouse or domestic partner is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

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

.

CHAPTER 2:
Important phone numbers and resources

SECTION 1 Tufts Health Plan Senior Care Options contacts (how to contact us, including how to reach Member Services)

How to contact our plan's Member Services

For assistance with claims, billing, or member card questions, please call or write to Tufts Health Plan Senior Care Options Member Services. We will be happy to help you.

Method	Member Services – Contact Information
CALL	1-855-670-5934 Calls to this number are free. Representatives are available 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31 and Monday - Friday from April 1 to September 30. After hours and holidays, please leave a message and a representative will return your call on the next business day. Member Services also has free language interpreter services available for members who require translation services.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Representatives are available 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31 and Monday - Friday from April 1 to September 30. After hours and holidays, please leave a message and a representative will return your call on the next business day.
FAX	1-617-972-9487
WRITE	Tufts Health Plan Senior Care Options Attn: Member Services P.O. Box 494 Canton, MA 02021-1166
WEBSITE	www.thpmp.org/sco

How to contact us when you are asking for a coverage decision about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For more information on asking for coverage decisions about your medical care, see Chapter 8 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

Method	Coverage Decisions for Medical Care – Contact Information
CALL	1-855-670-5934 Calls to this number are free. Representatives are available 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31 and Monday - Friday from April 1 to September 30. After hours and holidays, please leave a message and a representative will return your call on the next business day. Member Services also has free language interpreter services available for members who require translation services.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Representatives are available 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31 and Monday - Friday from April 1 to September 30. After hours and holidays, please leave a message and a representative will return your call on the next business day.
FAX	1-617-972-9487
WRITE	Tufts Health Plan Senior Care Options Attn: Member Services P.O. Box 494 Canton, MA 02021-1166
WEBSITE	www.thpmp.org/sco

How to contact us when you are asking for an appeal about your medical care

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on asking for appeals about your medical care, see Chapter 8 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

Method	Appeals for Medical Care – Contact Information
CALL	1-855-670-5934 Calls to this number are free. Representatives are available 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31 and Monday - Friday from April 1 to September 30. After hours and holidays, please leave a message and a representative will return your call on the next business day. Member Services also has free language interpreter services available for members who require translation services.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Representatives are available 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31 and Monday - Friday from April 1 to September 30. After hours and holidays, please leave a message and a representative will return your call on the next business day.
FAX	1-617-972-9516
WRITE	Tufts Health Plan Senior Care Options Attn: Appeals & Grievances P.O. Box 474 Canton, MA 02021-1166
WEBSITE	www.thpmp.org/sco

How to contact us when you are making a complaint about your medical care

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your medical care, see Chapter 8 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

Method	Complaints about Medical Care – Contact Information
CALL	1-855-670-5934 Calls to this number are free. Representatives are available 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31 and Monday - Friday from April 1 to September 30. After hours and holidays, please leave a message and a representative will return your call on the next business day. Member Services also has free language interpreter services available for members who require translation services.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Representatives are available 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31 and Monday - Friday from April 1 to September 30. After hours and holidays, please leave a message and a representative will return your call on the next business day.
FAX	1-617-972-9516
WRITE	Tufts Health Plan Senior Care Options Attn: Appeals & Grievances P.O. Box 474 Canton, MA 02021-1166
MEDICARE WEBSITE	You can submit a complaint about Tufts Health Plan Senior Care Options directly to Medicare. To submit an online complaint to Medicare go to www.medicare.gov/MedicareComplaintForm/home.aspx.

How to contact us when you are asking for a coverage decision about your Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your Part D prescription drugs. For more information on asking for coverage decisions about your Part D prescription drugs, see Chapter 8 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

Method	Coverage Decisions for Part D prescription drugs – Contact Information
CALL	1-855-670-5934 Calls to this number are free. Representatives are available 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31 and Monday - Friday from April 1 to September 30. After hours and holidays, please leave a message and a representative will return your call on the next business day. Member Services also has free language interpreter services available for members who require translation services.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Representatives are available 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31 and Monday - Friday from April 1 to September 30. After hours and holidays, please leave a message and a representative will return your call on the next business day.
FAX	1-617-673-0956
WRITE	Tufts Health Plan Senior Care Options Attn: Member Services P.O. Box 494 Canton, MA 02021-1166
WEBSITE	www.thpmp.org/sco

How to contact us when you are asking for an appeal about your Part D prescription drugs

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on asking for appeals about your Part D prescription drugs, see Chapter 8 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

Method	Appeals for Part D prescription drugs – Contact Information
CALL	1-855-670-5934 Calls to this number are free. Representatives are available 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31 and Monday - Friday from April 1 to September 30. After hours and holidays, please leave a message and a representative will return your call on the next business day. Member Services also has free language interpreter services available for members who require translation services.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Representatives are available 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31 and Monday - Friday from April 1 to September 30. After hours and holidays, please leave a message and a representative will return your call on the next business day.
FAX	1-617-972-9516
WRITE	Tufts Health Plan Senior Care Options Attn: Appeals & Grievances P.O. Box 474 Canton, MA 02021-1166
WEBSITE	www.thpmp.org/sco

How to contact us when you are making a complaint about your Part D prescription drugs

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your medical care, see Chapter 8 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

Method	Complaints about Part D prescription drugs – Contact Information
CALL	1-855-670-5934 Calls to this number are free. Representatives are available 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31 and Monday - Friday from April 1 to September 30. After hours and holidays, please leave a message and a representative will return your call on the next business day. Member Services also has free language interpreter services available for members who require translation services.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Representatives are available 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31 and Monday - Friday from April 1 to September 30. After hours and holidays, please leave a message and a representative will return your call on the next business day.
FAX	1-617-972-9516
WRITE	Tufts Health Plan Senior Care Options Attn: Appeals & Grievances P.O. Box 474 Canton, MA 02021-1166
MEDICARE WEBSITE	You can submit a complaint about Tufts Health Plan Senior Care Options directly to Medicare. To submit an online complaint to Medicare go to www.medicare.gov/MedicareComplaintForm/home.aspx.

Where to send a request asking us to pay for the cost for medical care or a drug you have received

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 6 (*Asking us to pay a bill you have received for covered medical services or drugs*).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 8 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) for more information.

Method	Payment Requests – Contact Information
CALL	1-855-670-5934 Calls to this number are free. Representatives are available 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31 and Monday - Friday from April 1 to September 30. After hours and holidays, please leave a message and a representative will return your call on the next business day. Member Services also has free language interpreter services available for members who require translation services.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Representatives are available 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31 and Monday - Friday from April 1 to September 30. After hours and holidays, please leave a message and a representative will return your call on the next business day.
FAX	1-617-972-1028
WRITE	Tufts Health Plan Senior Care Options P.O. Box 518 Canton, MA 02021-1166
WEBSITE	www.thpmp.org/sco

SECTION 2 Medicare
(how to get help and information directly from the Federal Medicare program)

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called "CMS"). This agency contracts with Medicare Advantage organizations including us.

Method	Medicare – Contact Information
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	www.Medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in Massachusetts. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans.

Method	Medicare – Contact Information
WEBSITE (continued)	You can also use the website to tell Medicare about any complaints you have about Tufts Health Plan Senior Care Options: • **Tell Medicare about your complaint:** You can submit a complaint about Tufts Health Plan Senior Care Options directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website and review the information with you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

SECTION 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Massachusetts, the SHIP is called SHINE (Serving the Health Insurance Needs of Everyone).

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

SHINE counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. SHINE counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

METHOD TO ACCESS SHIP and OTHER RESOURCES:

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

Method	SHINE (Serving the Health Insurance Needs of Everyone) (Massachusetts' SHIP) – Contact Information
CALL	1-800-243-4636
TTY	1-800-439-2370 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Call the number above for the address of the SHINE program in your area.
WEBSITE	www.mass.gov/health-insurance-counseling

SECTION 4 Quality Improvement Organization

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

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

You should contact KEPRO in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

Method	KEPRO (Massachusetts' Quality Improvement Organization) – Contact Information
CALL	1-888-319-8452 Monday - Friday: 9:00 a.m. - 5:00 p.m. Weekends - Holidays: 11:00 a.m. - 3:00 p.m. 24-hour voicemail service is available. Translation services are available for beneficiaries and caregivers who do not speak English.
TTY	711

Method	KEPRO (Massachusetts' Quality Improvement Organization) – Contact Information
	This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	KEPRO BFCC-QIO Program 5700 Lombardo Center Drive, Suite 100 Seven Hills, OH 44131
WEBSITE	www.keproqio.com

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for reconsideration.

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

Method	Social Security – Contact Information
CALL	1-800-772-1213 Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.

Method	Social Security – Contact Information
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday.
WEBSITE	www.ssa.gov

SECTION 6 MassHealth (Medicaid)

MassHealth (Medicaid) is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. MassHealth (Medicaid) offers different coverage types, including coverage for eligible seniors. One type of coverage is MassHealth Standard (Medicaid), the most complete coverage offered by MassHealth (Medicaid). It pays for a wide range of health care benefits, including long-term-care services. Some people with Medicare are also eligible for MassHealth Standard (Medicaid). Tufts Health Plan Senior Care Options members must be enrolled in MassHealth Standard (Medicaid).

MassHealth (Medicaid) pays for services not covered by Medicare and will cover certain services once the Medicare benefit is exhausted. See Chapter 4 in this booklet for more information about benefits covered by MassHealth Standard (Medicaid).

In addition, there are programs offered through MassHealth (Medicaid) that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)

If you have questions about the assistance you get from MassHealth (Medicaid), contact MassHealth (Massachusetts's Medicaid program).

Method	MassHealth (Massachusetts' Medicaid Program) – Contact Information
CALL	1-800-841-2900 Hours: Self-service available 24 hours a day in English and Spanish. Other services available Monday through Friday from 8:00 a.m. - 5:00 p.m. Interpreter service available. The MassHealth Enrollment Center (MEC) hours are Monday through Friday from 8:00 a.m. - 5:00 p.m.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	MassHealth Central Office 100 Hancock Street, 6th Floor Quincy, MA 02171
WEBSITE	www.mass.gov/topics/masshealth

MassOptions connects elders, individuals with disabilities and their caregivers with agencies and organizations that can best meet their needs.

Method	MassOptions – Contact Information
CALL	1-800-243-4636 Hours: 9 a.m.- 5 p.m., Monday – Friday. Online chat feature is also available.
TTY	N/A
WEBSITE	www.massoptions.org

The My Ombudsman helps people enrolled in MassHealth (Medicaid) with service or billing problems. They can help you file a grievance or appeal with our plan.

Method	My Ombudsman – Contact Information
CALL	1-855-781-9898 Available 9:00 a.m. to 4:00 p.m., Monday through Friday. Leave a message on the My Ombudsman secure voicemail system at any time.
Videophone	1-339-224-6831
WRITE	My Ombudsman 25 Kingston Street 4th Floor Boston, MA 02111 Email: info@myombudsman.org
WEBSITE	www.myombudsman.org

The *LTC Ombudsman Program* helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

Method	A Bridge to Quality Care, the Massachusetts Long Term Care Ombudsman – Contact Information
CALL	1-800-243-4636
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Executive Office of Elder Affairs One Ashburton Place, 5th Floor Boston, MA 02109
WEBSITE	www.mass.gov/service-details/ombudsman-programs

SECTION 7 Information about programs to help people pay for their prescription drugs

The Medicare.gov website) (https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap/5-ways-to-get-help-with-prescription-costs) provides information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, described below.

Medicare's "Extra Help" Program

Because you are eligible for MassHealth Standard (Medicaid), you qualify for and are getting "Extra Help" from Medicare to pay for your prescription drug plan costs. You do not need to do anything further to get this "Extra Help."

If you have questions about "Extra Help," call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048 (applications), 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 8 am to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778; or
- MassHealth (Medicaid) Office (applications) (See Section 6 of this chapter for contact information).

If you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has a process for you to either request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us.

- Please contact our Member Services Department if you need assistance with obtaining or proving best available evidence of your proper copayment level.
- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment, or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Member Services if you have questions.

SECTION 8 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

Method	Railroad Retirement Board – Contact Information
CALL	1-877-772-5772 Calls to this number are free. If you press "0," you may speak with an RRB representative from 9:00 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9:00 am to 12:00 pm on Wednesday. If you press "1", you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.
WEBSITE	rrb.gov/

SECTION 9 You can get assistance from Senior Agencies

In Massachusetts, the following agencies offer help to seniors aged 60 or older and their families, friends, and caregivers:

- **Aging Services Access Points** Aging Services Access Points (ASAPs) are one-stop entry points for all of the services and benefits available to seniors in Massachusetts. These agencies provide information, applications, direct services, and referrals.
- **Councils on Aging / Senior Centers** Councils on Aging (COAs) are local volunteer organizations that offer information and direct services to seniors, their caregivers, and other people with aging issues. COAs are part of the local government, and work with other senior agencies and city/town departments to provide social, recreational, health, safety, and educational programs for seniors in their communities.
- **MassOptions.org** is a website where seniors and their families can get information about programs and services for the elderly in Massachusetts. It is a service of the Massachusetts Executive Office of Health and Human Services.

For information on any of these agencies call MassOptions at 1-800-243-4636 or visit their web site at www.massoptions.org.

Aging Services Access Points (ASAPs) in Massachusetts

Aging Services Access Points (ASAPs) in Massachusetts | Mass.gov

LOCATIONS: Connect with home care services at Aging Service Access Points

ASAP	AgeSpan - Contact Information
CALL	1-978-683-7747 Toll Free: (800) 892-0890 **Areas served:** Amesbury, Andover, Billerica, Boxford, Chelmsford, Danvers, Dracut, Dunstable, Georgetown, Groveland, Haverhill, Lawrence, Lowell, Marblehead, Merrimack, Methuen, Middleton, Newbury, Newburyport, North Andover, Peabody, Rowley, Salem, Salisbury, Tewksbury, Tyngsboro, West Newbury, Westford
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.
ADDRESS	280 Merrimack Street, Suite 400 Lawrence, MA 01843
WEBSITE	http://www.agespan.org

ASAP	Aging Services of North Central Massachusetts - Contact Information
CALL	1-978-537-7411 **Areas served:** Ashburnham, Ashby, Ayer, Berlin, Bolton, Clinton, Fitchburg, Gardner, Groton, Hubbardston, Lancaster, Leominster, Pepperell, Princeton, Shirley, Sterling, Templeton, Townsend, Westminster, Winchendon
ADDRESS	680 Mechanic Street, Suite 120 Leominster, MA 01453
WEBSITE	https://www.agingservicesma.org/

ASAP	Boston Senior Home Care - Contact Information
CALL	1-617-292-6211 **Areas served:** Boston neighborhoods of Beacon Hill, Boston, Charlestown, Dorchester, Downtown, East Boston, North End, South Boston, South Cove, West End
ADDRESS	89 South Street, Lincoln Plaza Suite 501 Boston, MA 02111
WEBSITE	https://www.bshcinfo.org

ASAP	Bristol Elder Services, Inc. - Contact Information
CALL	1-508-675-2101 **Areas served:** Attleborough, Berkley, Dighton, Fall River, Freetown, Mansfield, North Attleborough, Norton, Raynham, Rehoboth, Seekonk, Somerset, Swansea, Taunton, Westport
ADDRESS	1 Father DeValles Blvd., Unit 8 Fall River, MA 02723
WEBSITE	http://www.bristolelder.org

ASAP	Central Boston Elder Services - Contact Information
CALL	1-617-277-7416 **Areas served:** Boston neighborhoods of Allston, Back Bay, Boston, Brighton, Fenway, Jamaica Plain, Kenmore/Fenway, Mission Hill, Roxbury, South End
ADDRESS	2315 Washington Street Boston, MA
WEBSITE	https://centralboston.org/

ASAP	Coastline Elderly Services, Inc. - Contact Information
CALL	1-508-999-6400 **Areas served:** Acushnet, Dartmouth, Fairhaven, Gosnold, Marion, Mattapoisett, New Bedford, Rochester
ADDRESS	1646 Purchase Street New Bedford, MA 02740
WEBSITE	http://www.coastlineelderly.org

ASAP	Elder Services of Cape Cod and the Islands, Inc. - Contact Information
CALL	1-508-394-4630 **Areas served:** Aquinnah, Barnstable, Bourne, Brewster, Buzzards Bay, Chatham, Chilmark, Dennis, Eastham, Edgartown, Falmouth, Gay Head, Harwich, Hyannis, Mashpee, Nantucket, Oak Bluffs, Orleans, Provincetown, Sandwich, Tisbury, Truro, Wellfleet, West Tisbury, Yarmouth
ADDRESS	68 Route 134 South Dennis, MA 02660
WEBSITE	http://www.escci.org

ASAP	Elder Services of Worcester Area, Inc. - Contact Information
CALL	1-508-756-1545 **Areas served:** Auburn, Barre, Boylston, Grafton, Hardwick, Holden, Leicester, Millbury, New Braintree, Oakham, Paxton, Rutland, Shrewsbury, West Boylston, Worcester
ADDRESS	67 Millbrook Street, Suite 100 Worcester MA 01606
WEBSITE	http://www.eswa.org

ASAP	**Elder Services of Worcester Area, Inc. - Contact Information**
ASAP	**Greater Lynn Senior Services, Inc. - Contact Information**
CALL	1-781-599- 0110 **Areas served:** Lynn, Lynnfield, Nahant, Saugus, Swampscott
ADDRESS	8 Silsbee St. Lynn, MA 01901
WEBSITE	http://www.glss.net

ASAP	**Ethos - Contact Information**
CALL	1-617-522-6700 **Areas served:** Boston neighborhoods of Jamaica Plain, Roslindale, West Roxbury, Hyde Park and Mattapan
ADDRESS	555 Amory Street Jamaica Plain, MA 02130
WEBSITE	https://www.ethocare.org/

ASAP	**Greater Springfield Senior Services, Inc. - Contact Information**
CALL	1-413-781-8800 1-413-781-0632 **Areas served:** Agawam, Brimfield, East Longmeadow, Hampden, Holland, Longmeadow, Monson, Palmer, Springfield, Wales, West Springfield, Wilbraham
ADDRESS	66 Industry Ave. Springfield, MA 01104
WEBSITE	http://www.gsssi.org

ASAP	HESSCO Elder Services - Contact Information
CALL	1-781-784-4944 **Areas served:** Canton, Dedham, Foxborough, Medfield, Millis, Norfolk, Norwood, Plainville, Sharon, Walpole, Westwood, Wrentham
ADDRESS	One Merchant St. Sharon, MA 02067
WEBSITE	http://www.hessco.org

ASAP	Highland Valley Elder Services, Inc. - Contact Information
CALL	1-413-586-2000 **Areas served:** Amherst, Blandford, Chester, Chesterfield, Cummington, Easthampton, Goshen, Granville, Hadley, Hatfield, Huntington, Middlefield, Montgomery, Northampton, Pelham, Plainfield, Russell, Southampton, Southwick, Tolland, Westfield, Westhampton, Williamsburg, Worthington
ADDRESS	320 Riverside Drive Suite B Florence, MA 01062
WEBSITE	http://www.highlandvalley.org

ASAP	LifePath, Inc. - Contact Information
CALL	1-413-773-5555 **Areas served:** Ashfield, Athol, Bernardston, Buckland, Charlemont, Colrain, Conway, Deerfield, Erving, Gill, Greenfield, Hawley, Heath, Leverett, Leyden, Monroe, Montague, New Salem, Northfield, Orange, Petersham, Phillipston, Rowe, Royalston, Shelburne, Shelburne Falls, Shutesbury, Sunderland, Turner Falls, Warwick, Wendell, Whately
ADDRESS	101 Munson St., Suite 201 Greenfield, MA 01301
WEBSITE	http://LifePathMA.org

ASAP	Minuteman Senior Services - Contact Information
CALL	1-781-272-7177 **Areas served:** Acton, Arlington, Bedford, Boxborough, Burlington, Carlisle, Concord, Harvard, Lexington, Lincoln, Littleton, Maynard, Stow, Wilmington, Winchester, Woburn
ADDRESS	26 Crosby Drive Bedford, MA 01730
WEBSITE	http://www.minutemansenior.org

ASAP	Mystic Valley Elder Services, Inc. - Contact Information
CALL	1-781-324-7705 **Areas served:** Chelsea, Everett, Malden, Medford, Melrose, North Reading, Reading, Revere, Stoneham, Wakefield, Winthrop
ADDRESS	300 Commercial Street, Suite #19 Malden, MA 02148
WEBSITE	http://www.mves.org

ASAP	Old Colony Elder Services, Inc. - Contact Information
CALL	1-508-584-1561 **Areas served:** Abington, Avon, Bridgewater, Brockton, Carver, Duxbury, East Bridgewater, Easton, Halifax, Hanover, Hanson, Kingston, Lakeville, Marshfield, Middleborough, Pembroke, Plymouth, Plympton, Rockland, Stoughton, Wareham, West Bridgewater, Whitman
ADDRESS	144 Main St. Brockton, MA 02301
WEBSITE	https://www.ocesma.org

ASAP	SeniorCare, Inc. - Contact Information
CALL	1-978-281-1750 **Areas served:** Beverly, Essex, Gloucester, Hamilton, Ipswich, Manchester-by-the-Sea, Rockport, Topsfield, Wenham
ADDRESS	49 Blackburn Center Gloucester, MA 01930
WEBSITE	https://seniorcareinc.org

ASAP	Somerville/Cambridge Elder Services, Inc. - Contact Information
CALL	1-617-628-2601 **Areas served:** Cambridge, Somerville
ADDRESS	61 Medford Street Somerville, MA 02143
WEBSITE	https://eldercare.org

ASAP	South Shore Elder Services, Inc. - Contact Information
CALL	1-781-848-3910 **Areas served:** Braintree, Cohasset, Hingham, Holbrook, Hull, Milton, Norwell, Quincy, Randolph, Scituate, Weymouth
ADDRESS	1515 Washington Street Braintree, MA 02184
WEBSITE	http://www.sselder.org

ASAP	Springwell Inc. - Contact Information
CALL	1-617-926-4100 **Areas served:** Ashland, Belmont, Brookline, Chestnut Hill, Dover, Framingham, Holliston, Hopkinton, Hudson, Marlborough, Natick, Needham, Newton, Northborough, Sherborn, Southborough, Sudbury, Waltham, Watertown, Wayland, Wellesley, Westborough, Weston
ADDRESS	307 Waverly Oaks Rd, Suite 205 Waltham, MA 02452
WEBSITE	http://www.springwell.com

ASAP	Tri-Valley, Inc. - Contact Information
CALL	1-508-949-6640 **Areas served:** Bellingham, Blackstone, Brookfield, Charlton, Douglas, Dudley, East Brookfield, Franklin, Hopedale, Medway, Mendon, Milford, Millville, North Brookfield, Northbridge, Oxford, Southbridge, Spencer, Sturbridge, Sutton, Upton, Uxbridge, Warren, Webster, West Brookfield
ADDRESS	10 Mill Street Dudley, MA 01571
WEBSITE	http://www.trivalleyinc.org

ASAP	WestMass Elder Care, Inc. - Contact Information
CALL	1-413-538-9020 **Areas served:** Belchertown, Chicopee, Granby, Holyoke, Ludlow, South Hadley, Ware
ADDRESS	4 Valley Mill Rd Holyoke, MA 01040
WEBSITE	http://www.wmeldercare.org

CHAPTER 3:
Using the plan for your medical and other covered services

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

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

For the details on what medical care and other services are covered by our plan, use the benefits chart in the next chapter, Chapter 4 (*Medical Benefits Chart, what is covered).*

Section 1.1 What are network providers and covered services?

- **Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.
- **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay nothing for covered services.
- **Covered services** include all the medical care, health care services, supplies equipment, and Prescription Drugs that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

Section 1.2 Basic rules for getting your medical care and other services covered by the plan

As a Medicare and MassHealth Standard (Medicaid) health plan, Tufts Health Plan Senior Care Options must cover all services covered by Original Medicare and may offer other services in addition to those covered under Original Medicare.

Tufts Health Plan Senior Care Options will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this document).
- **The care you receive is considered medically necessary**. Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

- **You have a network primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).
    - In most situations, your network PCP must give you approval in advance before you can use other providers in the plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a referral. For more information about this, see Section 2.3 of this chapter.
    - Referrals from your PCP are not required for emergency care or urgently needed services. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.2 of this chapter).
- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. This means that you will have to pay the provider in full for the services furnished. *Here are three exceptions:*
    - The plan covers emergency care or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.
    - If you need medical care that Medicare or MassHealth (Medicaid) requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider upon referral from your PCP. In this situation, we will cover these services at no cost to you. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.
    - The plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay the plan for dialysis can never exceed the cost sharing in Original Medicare. If you are outside the plan's service area and obtain the dialysis from a provider that is outside the plan's network, your cost sharing cannot exceed the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to obtain services inside the service area from a provider outside the plan's network the cost sharing for the dialysis may be higher. Because you get assistance from MassHealth (Medicaid), you have no cost-share for covered services.

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

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

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

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

What types of providers may act as a PCP?

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

How do you get care from your PCP?

You will usually see your PCP/Primary Care Team (PCT) first for most of your health care needs. Your PCP/PCT will provide most of your care and will help arrange or coordinate the rest of the covered services you get as a plan member. This includes your X-rays, laboratory tests, therapies, care from doctors who are specialists, hospital admissions, and follow-up care.

Sometimes you may need to talk with your Primary Care Physician (PCP) or get medical care when your PCP's office is closed. If you have a non-emergency situation and need to talk to your PCP after hours, you can call your PCP's office at any time and there will be a physician on call to help you. Hearing or speech-impaired members with TTY machines can call the Massachusetts Relay Association at TTY 1-800-439-2370 for assistance contacting your PCP/PCT after hours. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. (The non-TTY number for the Massachusetts Relay Association is 1-800-439-0183.)

What is the role of the PCP/PCT in coordinating covered services?

"Coordinating" your services includes talking with you and other plan providers about your care. These other plan providers, such as a Geriatric Support Service Coordinator (GSSC), nurse practitioner, registered nurse, or physician's assistant, may join up with you and your PCP to form your Primary Care Team (or "PCT") to help coordinate your care. If you need certain types of covered services or supplies, your PCP, after checking with you and your PCT, may also refer you to a plan specialist. Your PCP may have certain plan specialists that can provide the best care for you. That plan specialist may be someone who works with your PCP and PCT on a

regular basis and can coordinate your care more smoothly and timely. (Of course, in the event of an emergency, if you need urgent care, or you are out of the service area, you don't need a referral to seek medical services). Also, your referral may be time limited. In some cases, your PCP will need to get prior approval from us.

If you need Skilled Nursing Facility, Long Term Care or Home and Community Based services, your PCT will direct you to a subset of the facilities in our Tufts Health Plan SCO network, who can best coordinate your care and meet your individual needs. You will work with your PCT to select a facility from the identified options.

Since your PCP and PCT will either provide or coordinate your care, you should have all of your past medical records sent to your PCP's office for their use.

What is the role of the PCP/PCT in making decisions about or obtaining prior authorization?

Certain drugs, equipment, services, and supplies require authorization from Tufts Health Plan Senior Care Options prior to services being rendered. For out-of-network services, your PCP is responsible for obtaining an authorization or providing you with a referral depending on the services being rendered. Your PCP or other network provider is responsible for obtaining this authorization. Please be sure to check with your PCP or other network provider to be sure this authorization or referral has been provided.

How do you choose your PCP?

When you are deciding on a PCP, you may refer to our *Provider and Pharmacy Directory*. Once you have made a choice, you should call Member Services (see the number on the back of this booklet). A Member Services representative will verify that the PCP you have chosen is in the network. If you are making a change, the change will be effective the 1st of the following month, and you will automatically receive a new member ID card in the mail reflecting this change. If you are to be admitted to a particular hospital, check the *Provider and Pharmacy Directory*, or speak with a Member Services representative to be sure your PCP of choice uses that hospital.

Changing your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP. If you change your PCP, you should work with your new PCP to coordinate referrals to specialists within our network with whom she/he works on a regular basis to ensure that your medical care is coordinated as effectively as possible.

To change your PCP, call Member Services. They will also check to be sure the PCP you want to switch to is in the network and accepting new patients. ***If the PCP is in the network and accepting new patients, you will be able to make an appointment with your new PCP beginning the first of the following month.*** Member Services will change your membership record to show the name of your new PCP and will send you a new membership card that shows

the name and phone number of your new PCP. We suggest that you make an appointment with and arrange for your records to be transferred to your new PCP.

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

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

- Routine women's health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider
- Flu shots, COVID-19 vaccinations, Hepatitis B vaccinations, and pneumonia vaccinations as long as you get them from a network provider
- Emergency services from network providers or from out-of-network providers
- Urgently needed services are covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. If possible, please call Member Services before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away.
- Routine dental care provided by a network dentist
- Medicare-covered preventive services as long as you get them from a network provider

Section 2.3 How to get care from specialists and other network providers

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- Oncologists care for patients with cancer
- Cardiologists care for patients with heart conditions
- Orthopedists care for patients with certain bone, joint, or muscle conditions

What is the role of the PCP in referring members to specialists and other providers?

Generally, PCPs provide basic preventive care and treatment for common illnesses. For services your PCP can't provide, he/she will help arrange or coordinate the rest of the covered services you get as a plan member by referring you to a specialist.

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

Certain drugs, equipment, services, and supplies require authorization from Tufts Health Plan Senior Care Options prior to services being rendered. Your PCP or other network provider is responsible for obtaining this authorization. Please be sure to check with your PCP or other network provider to be sure this authorization or referral has been provided. For out-of-network services, your PCP is responsible for obtaining an authorization or providing you with a referral depending on the services being rendered.

For information about which services require prior authorization, see Chapter 4, Section 2.1. Services that require prior authorization are noted with an asterisk in the Medical Benefits Chart in Chapter 4. You can also call Member Services at the number on the back of this booklet for a list of services requiring your PCP or other network provider to obtain prior authorizations from the plan. Please refer to your Tufts Health Plan Senior Care Options Formulary for drugs that require prior authorization.

What is a referral?

A referral is an approval from your PCP to seek care from another health care professional, usually a specialist, for treatment or consultation. If you need certain types of covered services or supplies, your PCP must give approval in advance (such as referring you to a specialist). **Your PCP may have certain plan specialists that can provide the best care for you**. If your PCP refers you to a specialist, s/he may send you to a specialist with whom s/he works on a regular basis to assure that your medical care is coordinated as effectively as possible. For emergency or urgent care situations, out-of-area renal dialysis, or other services referrals are not required.

In some cases, your PCP will also need to get prior authorization (prior approval) in addition to providing a referral. Services that require prior authorization are noted in ***bold italics*** in the Medical Benefits Chart in Chapter 4. Services that require a referral are noted within the Medical Benefits Chart in Chapter 4. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office.

What if a specialist or another network provider leaves our plan?

We may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. If your doctor or specialist leaves your plan you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will notify you that your provider is leaving our plan so that you have time to select a new provider.
    - If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.
    - If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.
- We will assist you in selecting a new qualified in-network provider that you may access for continued care.
- If you are currently undergoing medical treatment or therapies with your current provider, you have the right to request, and we will work with you to ensure, that the medically necessary treatment or therapies you are receiving continues.
- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.
- We will arrange for any medically necessary covered benefit outside of our provider network but at in-network cost sharing when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. Except in an emergency or for urgently needed services, you must get a referral from your PCP and/or receive prior authorization from the plan prior to receiving care out-of-network. Because you get assistance from MassHealth (Medicaid), you have no cost-share for covered services.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file a quality-of-care complaint to the QIO, a quality of care grievance to the plan, or both. Please see Chapter 8.

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

Your PCP or network provider will provide a referral for you to see an out-of-network provider if no network provider is available. You or your authorized representative may also submit a request to Tufts Health Plan Senior Care Options. Authorization from Tufts Health Plan Senior Care Options may be required based on the service to be rendered. If you use out-of-network providers without a referral or authorization, payment will not be made by Tufts Health Plan Senior Care Options. See Chapter 4 for more information.

Under limited circumstances, our plan will allow our members to see out-of-network providers. These circumstances include seeing a provider with a specialty not currently contracted with our plan. We have contracted with providers across our service area to ensure access to care for our

members. You must get a referral from your PCP and receive prior authorization from the plan prior to receiving care out-of-network.

If you need medical care that Medicare requires our plan to cover and the providers in our network cannot provide that medical care, you can get this care from an out-of-network provider and/or facility. However, authorization must be obtained from the plan prior to seeking care. In this situation, if the service is approved, you will pay the same as you would pay if you got the care from a network provider. You, your PCP, or your representative may call, write or fax our plan to make a request for authorization. For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, "How to contact us when you are asking for a coverage decision about your medical care."

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

- The plan covers emergency care or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area and are not able to access contracted End-Stage Renal Disease (ESRD) providers.

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

Section 3.1 Getting care if you have a medical emergency

What is a medical emergency and what should you do if you have one?

A **medical emergency** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent your loss of life, loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP. You do not need to use a network doctor. You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they are not part of our network. The plan also offers worldwide coverage for emergency/ urgently needed care.

- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Please contact our number at 1-855-670-5934. (TTY 711). Hours are 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31 and Monday – Friday from April 1 to September 30. After hours and on holidays, please leave a message and a representative will return your call on the next business day.

What is covered if you have a medical emergency?

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

The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us and make plans for additional care. Your follow-up care will be covered by our plan. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

Our plan covers emergency medical care worldwide through your MassHealth (Medicaid) benefit. Medicare does not provide coverage for emergency or urgent care services outside the US and its territories.

What to do if you have a behavioral health emergency

In a behavioral health emergency, you should go to the nearest emergency room. You will be evaluated by a crisis team that will assist in finding you an appropriate facility for care. No prior authorization is required for this type of emergency within the U.S. and its territories. To learn more, see the Medical Benefits Chart in Chapter 4, Section 2.1.

You can also contact the Massachusetts Emergency Services Program (ESP) at 1-877-382-1609. ESP provides behavioral health crisis assessment, intervention, and stabilization services, 24 hours a day, seven days per week, and 365 days a year. ESP includes three services:

1. Mobile Crisis Intervention (MCI) services for adults – these services are available 24 hours a day, seven days a week, as follows: from 7 a.m. to 8 p.m. at all ESP community-based locations, and from 8 p.m. to 7 a.m. at residential programs and hospital emergency departments.
2. Emergency Services Program (ESP) community-based locations – hours vary based on location. For details, go to http://www.masspartnership.com/pdf/MBHPESPDirectory.pdf.

3. Community crisis stabilization (CCS) services for people age 18 and older – these services are available 24 hours a day, seven days a week. For details, go to http://www.masspartnership.com/pdf/MBHPESPDirectory.pdf.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all. If it turns out that it was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor has said that it was *not* an emergency, we will cover additional care *only* if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care.
- – *or* – The additional care you get is considered "urgently needed services" and you follow the rules for getting this urgent care (for more information about this, see Section 3.2 below).

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

What are urgently needed services?

An urgently needed service is a non-emergency situation requiring immediate medical care but, given your circumstances, it is not possible or not reasonable to obtain these services from a network provider. The plan must cover urgently needed services provided out of network. Some examples of urgently needed services are i) a severe sore throat that occurs over the weekend or ii) an unforeseen flare-up of a known condition when you are temporarily outside the service area.

What if you are in the plan's service area when you have an urgent need for care?

You should always try to obtain urgently needed services from network providers. However, if providers are temporarily unavailable or inaccessible and it is not reasonable to wait to obtain care from your network provider when the network becomes available, we will cover urgently needed services that you get from an out-of-network provider.

If you believe you are experiencing an urgent, unforeseen, non-emergency medical situation, please contact your PCP immediately. You may also call Member Services (phone numbers are printed on the back cover of this booklet) for access to our 24-hour clinical advice and support line. If you are unable to do so, or if it is impractical for you to receive care with your PCP or a network provider, you can go to any provider or clinic that provides urgently needed care, or you can dial 911 for immediate help.

What if you are outside the plan's service area when you have an urgent need for care?

When you are outside the service area and cannot get care from a network provider, our plan will cover urgently needed services that you get from any provider.

Our plan covers urgently needed care worldwide through your MassHealth (Medicaid) benefit. Medicare does not provide coverage for emergency or urgent care services outside the US and its territories.

Section 3.3 Getting care during a disaster

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

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

If you cannot use a network provider during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost sharing. If you cannot use a network pharmacy during a disaster, you may be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5, Section 2.5 for more information.

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

Section 4.1 You can ask us to pay for covered services

If you have paid for your covered services, or if you have received a bill for covered medical services, go to Chapter 6 (*Asking us to pay a bill you have received for covered medical services or drugs*) for information about what to do. Because you get assistance from MassHealth (Medicaid), you have no cost share for covered services.

Section 4.2 What should you do if services are not covered by our plan?

Tufts Health Plan Senior Care Options covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4 of this document. If you receive services, including transportation to such services, not covered by our plan or services obtained out-of-network and were not authorized, you are responsible for paying the full cost of services.

If you have any questions about whether we will pay for any medical service or care that you are considering, including transportation to such services, you have the right to ask us whether we

will cover it before you get it. You also have the right to ask for this in writing. If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you have used up your benefit for that type of covered service. Paying for costs once a benefit limit has been reached will not apply toward the out-of-pocket maximum. You can call Member Services when you want to know how much of your benefit limit you have already used.

SECTION 5 How are your medical services covered when you are in a clinical research study?

Section 5.1 What is a clinical research study?

A clinical research study (also called a *clinical trial*) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically request volunteers to participate in the study.

Once Medicare approves the study, and you express interest, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study *and* you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. If you tell us that you are in a qualified clinical trial, then you are only responsible for the in-network cost sharing for the services in that trial. If you paid more, for example, if you already paid the Original Medicare cost-sharing amount, we will reimburse the difference between what you paid and the in-network cost sharing. However, you will need to provide documentation to show us how much you paid. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in any Medicare-approved clinical research study, you do *not* need to tell us or to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers. Please note that this does not include benefits for which our plan is responsible that include, as a component, a clinical trial or registry to assess the benefit. These include certain benefits specified under national coverage determination (NCDs) and investigational device trials (IDE) and may be subject to prior authorization and other plan rules.

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

If you participate in a study that Medicare has *not* approved, *you will be responsible for paying all costs for your participation in the study*.

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

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you receive as part of the study, including:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study
- An operation or other medical procedure if it is part of the research study
- Treatment of side effects and complications of the new care

After Medicare has paid its share of the cost for these services, our plan will pay the rest. Like for all covered services, you will pay nothing for the covered services you get in the clinical research study.

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

- Generally, Medicare will *not* pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were *not* in a study.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.

Do you want to know more?

You can get more information about joining a clinical research study by visiting the Medicare website to read or download the publication "Medicare and Clinical Research Studies." (The publication is available at: www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf.) You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

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

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

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

To get care from a religious non-medical health care institution, you must sign a legal document that says you are conscientiously opposed to getting medical treatment that is non-excepted.

- **Non-excepted** medical care or treatment is any medical care or treatment that is *voluntary* and *not required* by any federal, state, or local law.
- **Excepted** medical treatment is medical care or treatment that you get that is *not* voluntary or *is required* under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
    - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
    - – *and* – You must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

Medicare coverage limits apply as described in Chapter 4 under 'Inpatient Hospital Care'.

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 Will you own the durable medical equipment after making a certain number of payments under our plan?

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

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

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

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

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare do not count.

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

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage Tufts Health Plan Senior Care Options will cover:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents

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

If you leave Tufts Health Plan Senior Care Options or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

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

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

CHAPTER 4:
Medical Benefits Chart (what is covered)

SECTION 1 Understanding covered services

This chapter provides a Medical Benefits Chart that lists your covered services as a member of Tufts Health Plan Senior Care Options. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

Section 1.1 You pay nothing for your covered services

Because you get assistance from MassHealth (Medicaid), you pay nothing for your covered services as long as you follow the plans' rules for getting your care. (See Chapter 3 for more information about the plans' rules for getting your care.)

Section 1.2 What is the most you will pay for Medicare Part A and Part B covered medical services?

Note: Because our members also get assistance from MassHealth Standard (Medicaid), very few members ever reach this out-of-pocket maximum. You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

Because you are enrolled in a Medicare Advantage Plan, there is a limit on the amount you have to pay out-of-pocket each year for medical services that are covered under Medicare Part A and Part B. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. For calendar year 2024 this amount is $8,850.

Note: The following section may not apply to you. Because you get assistance from MassHealth (Medicaid), you have no out-of-pocket costs for covered services.

The amounts you pay for deductibles, copayments, and coinsurance for covered services count toward this maximum out-of-pocket amount. The amounts you pay for your Part D prescription drugs do not count toward your maximum out-of-pocket amount. If you reach the maximum out-of-pocket amount of $8,850, you will not have to pay any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by MassHealth (Medicaid) or another third party).

SECTION 2 Use the *Medical Benefits Chart* to find out what is covered

Section 2.1 Your medical, long-term care, and home and community-based benefits as a member of the plan

The Medical Benefits Chart on the following pages lists the services Tufts Health Plan Senior Care Options covers. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare and MassHealth Standard (Medicaid) covered services must be provided according to the coverage guidelines established by Medicare and MassHealth (Medicaid).
- Your services (including medical care, services, supplies, equipment, and Part B prescription drugs) *must* be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered unless it is emergent or urgent care or unless your plan or a network provider has given you a referral. This means that you will have to pay the provider in full for the services furnished.
- You have a primary care provider (a PCP) who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in the plan's network. This is called giving you a referral.
- Some of the services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us. Covered services that need approval in advance are marked in the Medical Benefits Chart in ***bold italics***.

Other important things to know about our coverage:

- You are covered by both Medicare and MassHealth (Medicaid). Medicare covers health care and prescription drugs. MassHealth (Medicaid) covers your cost sharing for Medicare services, including cost share for inpatient stays, office visits, and outpatient services. MassHealth (Medicaid) also covers services Medicare does not cover, like home and community-based services, long-term care, and transportation to and from medical appointments. Note that to be eligible for Tufts Health Plan Senior Care Options you must not have any other comprehensive health insurance, except Medicare.
- Like all Medicare health plans, we cover everything that Original Medicare covers. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2024* handbook. View it online at www.medicare.gov or ask for a copy

by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you.
- If Medicare adds coverage for any new services during 2024, either Medicare or our plan will cover those services.
- Under Tufts Health Plan Senior Care Options, some benefits are covered by Medicare, and some are covered by MassHealth (Medicaid). We integrate all benefits in providing service to you. The following benefit chart reflects all covered services and cost-sharing information.
- If you are within our plan's one-month period of deemed continued eligibility, we will continue to provide all Medicare Advantage plan-covered Medicare benefits. However, during this period, we will continue to cover MassHealth Standard (Medicaid) benefits that are included under the MassHealth (Medicaid) State Plan and will pay the Medicare premiums or cost-sharing for which the state would otherwise be liable. Medicare cost-sharing amounts for Medicare basic and supplemental benefits do not change during this period.

You do not pay anything for the services listed in the Benefits Chart, as long as you meet the coverage requirements described above.

Important Benefit Information for all Enrollees Participating in Wellness and Health Care Planning (WHP) Services

- Because Tufts Health Plan Senior Care Options participates in **Instant Savings** program that offers enhanced benefits including Medicare-approved over-the-counter (OTC) items, health and hygiene items, and healthy food, you will be eligible for the following WHP services, including advance care planning (ACP) services:

– What are Advance Care Planning (ACP) services?

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. Advance care planning involves discussing and preparing for future decisions about your medical care if you become seriously ill or unable to communicate your wishes. Advance care planning means making decisions ahead of time of what you want to happen if you are in this situation. This means that, if you want, you can:

- Fill out a written form to give someone the legal authority to make medical decisions for you if you ever become unable to make decisions for yourself.
- Give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself.
- You may get advance care planning assistance by contacting your Care Manager or Member Services (phone numbers are printed on the back cover of this booklet).

Important Benefit Information for Enrollees Who Qualify for "Extra Help":

- If you receive "Extra Help" to pay your Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance, you may be eligible for other targeted supplemental benefits and/or targeted reduced cost sharing.
- Please go to the Medical Benefits Chart in Chapter 4 for further detail.

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

Medical Benefits Chart

Services that are covered for you	**What you must pay** when you get these services
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, disease, etc.); • not associated with surgery; and An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the	You pay $0 for up to 20 Medicare-covered acupuncture visits per year from a licensed acupuncturist for the treatment of chronic low back pain.

Services that are covered for you	**What you must pay** when you get these services
Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27. **Additional Acupuncture Benefits** The plan covers services in excess of Medicare coverage, as well as for the treatment of other types of pain and as an anesthetic. Services must be provided by a licensed acupuncturist. Please refer to page 73 under Behavioral Health – Outpatient Services for additional acupuncture benefit information. *This benefit is covered by the plan under Medicare and MassHealth (Medicaid) benefits.*	***Prior authorization is required for acupuncture services beyond 20 visits.*** You pay $0 for additional acupuncture services by a licensed acupuncturist in excess of Medicare coverage, as well as for the treatment of other types of pain and as an anesthetic.
Adult Day Health Community-based services such as nursing, assistance with activities of daily living, social, therapeutic, recreation, and nutrition services at a site outside the home, and transportation to the authorized site outside the home. *This benefit is covered by the plan under the MassHealth (Medicaid) benefit.*	***Prior authorization may be required before you receive this service.*** You pay $0 for covered services.

Services that are covered for you	**What you must pay** when you get these services
Adult Foster Care (AFC) AFC is for members who need daily help with personal care but want to live in a family setting rather than in a nursing home or other facility. AFC members live with trained paid caregivers who provide daily care. Caregivers may be individuals, couples, or larger families. The caregiver provides personal care, assistance with medication adherence, meals, homemaking, laundry, medical transportation, companionship, and 24-hour supervision. *This benefit is covered by the plan under the MassHealth (Medicaid) benefit.*	You pay $0 for covered services.
Ambulance services Covered ambulance services whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. If the covered ambulance services are not for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. Ambulance services are covered worldwide. For more information about non-emergency transportation services covered by our plan under the MassHealth (Medicaid) benefit, see Transportation section listed later in this chart. *This benefit is covered by the plan under Medicare and MassHealth (Medicaid) benefits.*	You pay $0 for covered services. ***Prior authorization may be required for non-emergency transportation.***

Services that are covered for you	**What you must pay** when you get these services
Annual physical exam The Annual Physical Exam is a more comprehensive examination than an annual wellness visit. Services will include the following: bodily systems examinations, such as heart, lung, head and neck, and neurological system; measurement and recording of vital signs such as blood pressure, heart rate, and respiratory rate; a complete prescription medication review; and a review of any recent hospitalizations. Covered once every calendar year.	You pay $0 for covered services.
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every calendar year. **Note**: Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.
Breast cancer screening (mammograms) Covered services include: • One screening mammogram every 12 months • Clinical breast exams once every 24 months	There is no coinsurance, copayment, or deductible for covered screening mammograms.

Services that are covered for you	**What you must pay** when you get these services
Behavioral Health – Diversionary Services Those Behavioral Health services that are provided as alternatives to inpatient services, including, but not limited to: • Community Support • Crisis Stabilization • Observation/Holding Beds • Psychiatric Day Treatment • Acute Treatment Services (ATS) for Substance Use Disorders • Clinical Support Services (CSS) for Substance Use Disorders • Partial hospitalization services • Structured Outpatient Addiction Program (SOAP) • Intensive Outpatient Program (IOP) • Adult Residential Rehabilitation Services (RRS) for Substance Use Disorders • Program of Assertive Community Treatment (PACT) *This benefit is covered by the plan under Medicare and MassHealth (Medicaid) benefits.*	You pay $0 for covered services.
Behavioral Health – Emergency Services Medically necessary services that are available seven days per week, 24 hours per day to provide treatment of any member who is experiencing a behavioral health or substance use disorder problem, or both, including, but not limited to: • Emergency Screening Services • Medication Management Services • Short-Term Crisis Counseling • Short-Term Crisis Stabilization Services • Specialing Services *This benefit is covered by the plan under the MassHealth (Medicaid) benefit.*	You pay $0 for covered services.

Services that are covered for you	**What you must pay** when you get these services
Behavioral Health – Inpatient Services 24-hour services that provide medical intervention for behavioral health or substance use disorder diagnoses, or both, including, but not limited to: • Inpatient Behavioral Health Services • Inpatient Substance Use Disorder Services (Level IV) Please refer to page 92 under "Inpatient hospital care," and page 99 under "Opioid treatment program services" for additional benefit information. *This benefit is covered by the plan under the Medicare and MassHealth (Medicaid) benefit.*	You pay $0 for covered services.

Services that are covered for you	**What you must pay** when you get these services

Behavioral Health – Outpatient Services
 	
Behavioral health and substance use disorder services provided in person in an ambulatory care setting such as a behavioral health center or substance use disorder clinic, hospital outpatient department, community health center, or practitioner's office. Services include, but are not limited to:
 	
• Standard Outpatient Services
  ○ Family Consultation
  ○ Case Consultation
  ○ Diagnostic Evaluation
  ○ Dialectical Behavioral Therapy (DBT)
  ○ Psychiatric Consultation on an Inpatient Medical Unit
  ○ Medication Visit
  ○ Couples/Family, Group and/or Individual Treatment
  ○ Inpatient-Outpatient Bridge Visit
  ○ Acupuncture Treatment
  ○ Opioid Replacement Therapy
  ○ Ambulatory Detoxification
  ○ Psychological Testing
• Recovery Coaching
• Recovery Support Navigators (RSN)
 	
Please refer to page 102 under "Outpatient behavioral health care" for additional benefit information.
 	
This benefit is covered by the plan under the Medicare and MassHealth (Medicaid) benefit.
	You pay $0 for covered services.
	
	Before you receive Medication Visit and Opioid Replacement Therapy services, you must first obtain a referral from your PCP.

Services that are covered for you	**What you must pay** when you get these services

Behavioral Health – Emergency Services Program (ESP)
 	
Services provided through designated contracted ESPs, and which are available seven days per week, 24 hours per day to provide treatment of any member who is experiencing a behavioral health crisis. Services include, but are not limited to:
 	
• ESP Encounter
  ○ Assessment
  ○ Intervention
  ○ Stabilization
 	
This benefit is covered by the plan under the MassHealth (Medicaid) benefit.
	You pay $0 for covered services.

Behavioral Health – Special Procedures Services include, but not limited to: • Electroconvulsive Therapy • Psychological Neuropsychological Testing *This benefit is covered by the plan under the MassHealth (Medicaid) benefit.*	You pay $0 for covered services.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	You pay $0 for covered services.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.

Services that are covered for you	**What you must pay** when you get these services
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical or vaginal cancer and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services Covered services include: • Initial Chiropractic Evaluation • Manual manipulation of the spine to correct subluxation • Chiropractic manipulative treatment and radiology services. We cover up to 20 office visits or chiropractic manipulation treatments per year under the MassHealth Standard (Medicaid) benefit. *This benefit is covered by the plan under Medicare and MassHealth (Medicaid) benefits.*	You pay $0 for covered services. Before you receive services, you must first obtain a referral from your PCP.

Services that are covered for you	**What you must pay** when you get these services
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patient not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. Colorectal cancer screening tests include a follow-up screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam, including barium enemas. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam and you pay $0 copayment for your doctors' services.

Services that are covered for you	**What you must pay** when you get these services
Community Based Services Including but not limited to the following services: • Chore services • Companion services • Dementia and social day care • Environmental Accessibility Adaptations (Home Modification) • Grocery shopping and delivery • Homemaker • Home-delivered meals • Laundry service • Personal care services • Personal Emergency Response System (PERS) • Respite care • Transportation (to and from non-medical appointments) • Wander Response System Note: Environmental Accessibility Adaptations services provide home adaptations, modifications or adaptive equipment to help member remain independent or improve independence. *This benefit is covered by the plan under the MassHealth (Medicaid) benefit.*	***Except in an emergency, prior authorization may be required before you receive certain services.*** You pay $0 for covered services. Before you receive community-based services, you must first discuss these services with your Plan Care Manager. If you need Skilled Nursing Facility, Long-Term Care or Home and Community-Based services, your Primary Care Team (PCT) will direct you to a subset of the facilities in our Tufts Health Plan SCO network who can best coordinate your care and meet your individual needs. You will work with your PCT to select a facility from the identified options.
Continuous nursing services Continuous, specialized skilled nursing services. *This benefit is covered by the plan under the MassHealth (Medicaid) benefit.*	***You pay $0 for covered services.***

Services that are covered for you	**What you must pay** when you get these services
Day Habilitation Services A structured, goal-oriented, active treatment program of medically oriented, therapeutic, and habilitation services for developmentally disabled individuals who need active treatment. *This benefit is covered by the plan under the MassHealth (Medicaid) benefit.*	You pay $0 for covered services.
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. However, Medicare currently pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation. We cover Medicare-covered services by a dentist or oral surgeon that are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor. Additionally, we cover: <u>Preventive/Diagnostic:</u> • Preventive (cleanings) • Routine exam • X-rays <u>Restorative:</u> • Fillings • Crown • Replacement crown	***Except in an emergency, prior authorization may be required before you receive certain services.*** You pay $0 for covered services. Services must be performed by a DentaQuest provider. Limitations may apply. For more information, contact DentaQuest at 1-888-309-6508. TDD: 1-800-466-7566.

Services that are covered for you	**What you must pay** when you get these services
• Inlay • Endodontic therapy • Apicoectomy/periradicular surgery Periodontics: • Gingivectomy or gingivoplasty • Periodontal scaling and root planing Prosthodontics, removable: • Complete denture • Partial denture • Reline complete denture Prosthodontics, fixed Implant Services Oral and Maxillofacial Surgery: • Extractions (removing teeth) • Some oral surgery such as biopsies and soft-tissue surgery • Alveoloplasty • Oral and Maxillofacial Surgery Emergency Care Visits *This benefit is covered by the plan under the Medicare and MassHealth (Medicaid) benefits.*	
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.

Services that are covered for you	**What you must pay** when you get these services
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • The plan covers two additional pairs of therapeutic, custom-molded shoes under the MassHealth (Medicaid) benefits for members who have severe diabetic foot disease and meet the requirements as defined by Medicare. Coverage includes fitting. • Diabetes self-management training is covered under certain conditions. **Note:** For foot care related to diabetes, see Podiatry Services in this chart. *This benefit is covered by the plan under the Medicare and MassHealth (Medicaid) benefits.*	***Except in an emergency, prior authorization may be required before you receive certain diabetes self-management training, or diabetic services and supplies.*** There is no coinsurance, copayment, or deductible for beneficiaries eligible for the diabetes self-management training preventive benefit. Coverage for blood glucose monitors and blood glucose test strips is limited to the OneTouch products manufactured by LifeScan, Inc. Please note, there is no preferred brand for lancets or glucose control solutions. Covered therapeutic Continuous Glucose Monitors (CGMs) include Dexcom and FreeStyle Libre products that are considered Durable Medical Equipment (DME) by

Services that are covered for you	**What you must pay** when you get these services
	Medicare. Diabetic testing supplies, including test strips, lancets, glucose meters, and therapeutic Continuous Glucose Monitoring Systems are also covered at participating retail or mail-order pharmacies. Before you receive diabetes self-management training you must first obtain a referral from your PCP. You pay $0 for covered services.

Services that are covered for you	**What you must pay** when you get these services
Durable medical equipment (DME) and related supplies (For a definition of "durable medical equipment," see Chapter 12 as well as Chapter 3, Section 7 of this document.) Covered items include, but are not limited to: the purchase of medical equipment, replacement parts, and repairs for such items as: canes, crutches, wheelchairs (manual, motorized, custom fitted, and rentals), walkers, commodes, special beds, monitoring equipment, orthotic and prosthetic devices, and the rental of Personal Emergency Response System (PERS) and Wander Response System. Coverage includes related supplies and repair and replacement of the equipment. Coverage also includes ambulatory liquid oxygen systems and refills; aspirators; compressor-driven nebulizers; intermittent positive pressure breather (IPPB); oxygen; oxygen gas; oxygen-generating devices; and oxygen therapy equipment rental. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. *This benefit is covered by the plan under the Medicare and MassHealth (Medicaid) benefits.*	***Except in an emergency, prior authorization may be required before you obtain certain durable medical equipment and related supplies.*** You pay $0 for covered services.

Services that are covered for you	**What you must pay** when you get these services
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. Coverage includes inpatient and outpatient services, including behavioral health services that are needed to evaluate or stabilize a member's emergency medical condition. Emergency services include post-stabilization services provided after an emergency is stabilized in order to maintain the stabilized condition or to improve or resolve the member's condition. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer. Cost-sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. Your plan includes worldwide coverage for emergency care. *This benefit is covered by the plan under the Medicare and MassHealth (Medicaid) benefits.*	You pay $0 for covered services. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan.

Services that are covered for you	**What you must pay** when you get these services
Geriatric Support Services Coordination (GSSC) In-home assessment and home-based services coordination provided by a licensed social worker through an Aging Services Access Point (ASAP). *This benefit is covered by the plan under the MassHealth (Medicaid) benefit.*	You pay $0 for covered services.
Group Adult Foster Care (GAFC) GAFC includes personal care services for eligible members with disabilities who live in GAFC-approved housing. Housing may be an assisted-living residence or specially designated public or subsidized housing. *This benefit is covered by the plan under the MassHealth (Medicaid) benefit.*	You pay $0 for covered services.
Health and wellness education programs **YMCA Membership** We pay for membership at your local YMCA health club facility, located within our service area in Massachusetts. This benefit is provided to promote overall health and fitness as well as offer opportunities for social engagement. • Includes access to facilities and support staff. • Includes access to group movement classes (Tai Chi, group exercise, etc.), and health programs, based on availability. Additional cost may be required. Please contact your local YMCA facility for details. **Wellness Allowance** • Participation in YMCA group movement classes and health programs (for classes and programs associated with an additional fee)	The plan reimburses you up to $200 per year towards your cost for membership in a qualified health club or fitness facility, covered

Services that are covered for you	**What you must pay** when you get these services
• Participation in instructional fitness classes such as yoga, Pilates, Tai Chi and aerobics • Participation in online instructional fitness classes or membership fees for online fitness subscriptions, such as Peloton. • Membership in a qualified health club or fitness facility. A qualified health club or fitness facility provides cardiovascular and strength-training exercise equipment onsite. This benefit does not cover membership fees you pay to non-qualified health clubs or fitness facilities, including but not limited to martial arts centers; gymnastics facilities; country clubs, sports clubs and social clubs; and for sports activities such as golf and tennis. • Visits to a licensed nutritional counselor or licensed dietician for nutritional counseling services • Activity tracker (limit of one per member per year) Participation in: • an instructor-led "Matter of Balance" program • a chronic disease self-management program • the Diabetes workshop program • the Healthy Eating for Successful Living program • the Healthy IDEAS program • Powerful Tools for Caregivers • the Arthritis Foundation Exercise program • the Enhance Wellness program including memory fitness activities • the Fit For Your Life program • the AAA Senior Driving program To obtain this reimbursement please submit a Wellness Allowance reimbursement form along with proof of payment and any additional information outlined on the form. Call Member Services to request a reimbursement form or go to our website www.thpmp.org/sco. Send the completed form with	instructional fitness classes, participation in wellness programs such as Matter of Balance, chronic disease self-management, diabetes workshop, Healthy Eating for Successful Living, Healthy IDEAS, Powerful Tools for Caregivers, Arthritis Foundation Exercise, Enhance Wellness, Fit For Your Life, and AAA Senior Driving, memory fitness activities, an activity tracker (e.g. Fitbit, Apple watch, etc.), and/or covered nutritional counseling sessions with a licensed nutritional counselor or registered dietician. You pay all charges over $200 per year. Sales tax is not eligible for reimbursement. Reimbursement requests for a prior year must be received by Tufts Health Plan Senior Care Options no later than March 31 of the following year. No referral is required for this benefit.

Services that are covered for you	**What you must pay** when you get these services
any required documents to the address shown on the form. If you have any questions, contact Member Services. **Weight Management Programs** The Plan will cover program fees for weight loss programs such as WeightWatchers, , or a hospital-based weight loss program. This benefit does not cover costs for pre-packaged meals/foods, books, videos, scales, or other items or supplies. To obtain this reimbursement, please submit a Weight Management reimbursement form along with proof of payment and any additional information outlined on the form. Call Member Services to request a reimbursement form or go to our website www.thpmp.org/sco. Send the completed form with any required documents to the address shown on the form. If you have any questions, contact Member Services.	The plan will reimburse members up to $200 per year towards program fees for weight-loss programs. Sales tax is not eligible for reimbursement. Reimbursement requests must be received by Tufts Health Plan Senior Care Options by no later than March 31st of the following year.
Hearing services Diagnostic hearing and balance evaluations performed by your PCP to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. • Diagnostic hearing exams • Routine hearing test every calendar year Coverage also includes hearing aids or instruments, services related to the care, maintenance, and repair of hearing aids or instruments and supplies. Covers one aid per ear per member every 60 months. *This benefit is covered by the plan under the Medicare and MassHealth (Medicaid) benefits.*	You pay $0 for covered services. No referral is required for an annual routine hearing test, but you must use a Plan provider.

Services that are covered for you	**What you must pay** when you get these services
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
Home health agency care Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must meet medical criteria to qualify for these services. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week). Additional hours may be covered under your MassHealth (Medicaid) benefits. • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies • Assistance with activities of daily living *This benefit is covered by the plan under the Medicare and MassHealth (Medicaid) benefits.*	You pay $0 for home health care services. Limitations may apply.

Services that are covered for you	**What you must pay** when you get these services
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier *This benefit is covered by the plan under the Medicare benefit.*	***Except in an emergency, prior authorization is required before you receive certain home infusion therapy services.*** You pay $0 for Medicare-covered home infusion therapy.
Hospice care You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care <u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis</u>: Original Medicare (rather than our plan) will pay your hospice provider for your hospice services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost sharing. Because you get assistance from MassHealth Standard (Medicaid), this cost sharing will be covered by your MassHealth (Medicaid) benefit.	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Tufts Health Plan Senior Care Options. If you do not have Medicare coverage, your hospice services are covered under your Tufts Health Plan Senior Care Options benefits.

Services that are covered for you	**What you must pay** when you get these services
<u>For services that are covered by Medicare Part A or B and are not related to your terminal prognosis</u>: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (such as if there is a requirement to obtain prior authorization). • If you obtain the covered services from a network provider and follow plan rules for obtaining service, you only pay the plan cost-sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay the cost sharing under Fee-for-Service Medicare (Original Medicare) <u>For services that are covered by Tufts Health Plan Senior Care Options but are not covered by Medicare Part A or B:</u> Tufts Health Plan Senior Care Options will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. <u>For drugs that may be covered by the plan's Part D benefit:</u> If these drugs are unrelated to your terminal hospice condition you pay cost sharing. If they are related to your terminal hospice condition then you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.3 (*What if you're in Medicare-certified hospice*). **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit. *This benefit is covered by the plan under the Medicare and MassHealth (Medicaid) benefits.*	

Services that are covered for you	**What you must pay** when you get these services
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccine • Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover some vaccines under our Part D prescription drug benefit.	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines.

Services that are covered for you	**What you must pay** when you get these services
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. For care in a general acute care hospital, you are covered for as many days as medically necessary: there is no limit. Medicare benefit periods do not apply to acute hospital stays. For care in a rehabilitation or long-term acute care hospital you are covered up to 90 days each benefit period. You may use your 60 lifetime reserve days to supplement care in a rehabilitation or long-term hospital. Coverage is limited by prior, partial, or complete use of these days, which may only be used once in a lifetime. Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance use disorder services	***Except in an emergency, prior authorization is required before you receive certain inpatient hospital care. Prior authorization is not required for behavioral health inpatient hospital services, such as inpatient substance use disorder services.*** You pay $0 for covered services. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.

Services that are covered for you	**What you must pay** when you get these services
Inpatient hospital care (continued) • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If Tufts Health Plan Senior Care Options provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need because you have MassHealth Standard (Medicaid) coverage. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. *This benefit is covered by the plan under Medicare and MassHealth (Medicaid) benefits.*	

Services that are covered for you	**What you must pay** when you get these services
Inpatient behavioral health care • Covered services include behavioral health care services that require a hospital stay. These services are available 24 hours a day and provide medical intervention for behavioral health or substance use disorder diagnoses, or both. • Medicare covers up to 90 days per benefit period with a limit of up to 190 days of inpatient psychiatric hospital care in a lifetime. The 190-day limit does not apply to inpatient behavioral health services provided in a psychiatric unit of a general hospital. MassHealth Standard (Medicaid) benefits cover all approved stays in excess of the Medicare limit. • For inpatient behavioral health/substance use disorder services, you may be required to use the hospital designated by your Primary Care Physician (PCP/PCT) for behavioral health services. This may require a transfer from the hospital your PCP/PCT uses for medical and surgical services to the facility designated for behavioral health services. *This benefit is covered by the plan under the Medicare and MassHealth (Medicaid) benefits.*	You pay $0 for covered services.

Services that are covered for you	**What you must pay** when you get these services
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include but are not limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses; and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy *This benefit is covered by the plan under the Medicare and MassHealth (Medicaid) benefits.*	You pay $0 for covered services.
Institutional Care Services such as nursing, medical social work, assistance with activities of daily living, therapies, nutrition, and drugs and biologicals provided at a skilled nursing facility or other nursing facility. *This benefit is covered by the plan under the MassHealth (Medicaid) benefit.*	You pay $0 for covered services unless MassHealth (Medicaid) determines you have a monthly Patient Paid Amount (PPA) for which you are responsible.

Services that are covered for you	**What you must pay** when you get these services
	You must pay the PPA directly to the nursing facility. SCO members are followed throughout the continuum of health, including any time spent in a skilled nursing facility and/or long-term care facility. Tufts Health Plan Senior Care Options will direct you to selected facilities to best manage your specific needs while receiving care in an Institutional setting. Team members may include a Nurse Practitioner or Physician-assigned, facility-based and community-based care managers, and specialists. You will work with your Primary Care Team (PCT) to select a facility from the identified options. This means in most cases you will not have full access to the network facilities for these services. Exclusions include instances in which a spouse lives at a facility you are requesting or if you currently live in a facility and join our SCO Program.

Services that are covered for you	**What you must pay** when you get these services
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year. MassHealth (Medicaid) may cover medical nutrition therapy for members who do not meet the Medicare benefit. *This benefit is covered by the plan under the Medicare and MassHealth (Medicaid) benefits.*	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.
Medicare Part B prescription drugs These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services	***Except in an emergency, prior authorization is required before you obtain certain Medicare Part B prescription drugs.***

Services that are covered for you	**What you must pay** when you get these services
• Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Chemotherapy drugs Part B Step Therapy Drug Categories: • Rare Diseases • Autoimmune • Iron preparations, Parenteral • Oncology • Oncology, Supportive • Retinal Disorders • Triamcinolone Acetonide Injection • Viscosupplements • Botulinum Toxins • Endocrine Disorders The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: https://tuftshealthplan.com/documents/providers/pharmacy/part-b-step-therapy24	You pay $0 for covered services. Part B drugs may be subject to Step Therapy requirements.

Services that are covered for you	**What you must pay** when you get these services
We also cover some vaccines under our Part B and Part D prescription drug benefit. Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.	
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications. • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	You pay $0 for covered services.

Services that are covered for you	**What you must pay** when you get these services
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Diagnostic radiology services, such as ultrasound, PET, MRI and CT scan • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need because you have MassHealth Standard (Medicaid) coverage. • Other outpatient diagnostic tests including but not limited to sleep studies, EKG, stress tests, vascular studies, and breathing capacity tests *This benefit is covered by the plan under the Medicare and MassHealth (Medicaid) benefits.*	***Except in an emergency, prior authorization may be required before you obtain outpatient diagnostic tests and therapeutic services and supplies.*** You pay $0 for covered services.

Services that are covered for you	**What you must pay** when you get these services
Outpatient hospital services We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Behavioral health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. *This benefit is covered by the plan under the Medicare and MassHealth (Medicaid) benefits.*	***Except in an emergency, prior authorization may be required before you receive certain outpatient hospital services.*** You pay $0 for covered services. Before you receive services, you must first obtain a referral from your PCP.

Services that are covered for you	**What you must pay** when you get these services
Outpatient behavioral health care Covered services include: Behavioral health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family assistant (LMFT), nurse practitioner (NP), physician assistant, or other Medicare-qualified behavioral health care professional as allowed under applicable state laws. *This benefit is covered by the plan under the Medicare and MassHealth (Medicaid) benefits.*	You pay $0 for covered services. Before you receive services from a psychiatrist, you must first obtain a referral from your PCP. A referral is not required for all other Outpatient behavioral health care services.
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy, individual treatment (including the design, fabrication, and fitting of an orthotic, prosthetic or other assistive technology device), comprehensive evaluation and group therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs). *This benefit is covered by the plan under the Medicare and MassHealth (Medicaid) benefits.*	You pay $0 for covered services. Before you receive services, you must first obtain a referral from your PCP.

Services that are covered for you	**What you must pay** when you get these services
Outpatient substance use disorder services Coverage under Medicare Part B is available for treatment services that are provided in the outpatient department of a hospital to patients who, for example, have been discharged from an inpatient stay for the treatment of substance use disorder or who require treatment but do not require the availability and intensity of services found only in the inpatient hospital setting. The coverage available for these services is subject to the same rules generally applicable to the coverage of outpatient hospital services. *This benefit is covered by the plan under the Medicare and MassHealth (Medicaid) benefits.*	You pay $0 for covered services.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient." The plan covers gender reassignment services. Services may include the following: mastectomy, breast augmentation, hysterectomy, salpingectomy, oophorectomy, or genital reconstructive surgery. Services and procedures that are considered cosmetic and reversal of gender reassignment surgery are not covered. Your provider will be required to submit your medical records for review. For more information or help, please contact your care team. *This benefit is covered by the plan under the Medicare and MassHealth (Medicaid) benefits.*	***Except in an emergency, prior authorization may be required before you receive outpatient surgery.*** You pay $0 for covered services. Before you receive services, you must first obtain a referral from your PCP.

Services that are covered for you	**What you must pay** when you get these services
Over-the-Counter (OTC) items • Over-the-Counter (OTC) and prescription medicines: Please see OTC "Drug List" • Additional coverage for OTC Rx In addition to the OTC "Drug List", Tufts Health Plan Senior Care Options provides coverage for the following OTC Rx drugs: You have additional coverage for the following OTC Rx items: • Methylsulfonylmethane (MSM) • Glucosamine/Chondroitin/MSM • Glucosamine/MSM • Chondroitin/MSM • Omega 3/Fish Oil • Benzonatate • Robitussin Cough + Chest Congestion DM (liquid) • Mucinex 600 mg • Lidocaine 4% topical patch Non-brand-name (generic) OTC medications will be dispensed unless otherwise approved by Tufts Health Plan Senior Care Options. See formulary.	You pay $0 for covered OTC medications. Before you receive OTC medications you must first obtain a prescription from your treating provider.
Over-the-Counter (OTC) + Daily Health and Hygiene Items + Healthy Food – Instant Savings Card With this benefit, you will get a prepaid **Instant Savings card** loaded with credit each quarter to help you pay for eligible items, including national and store brands in the following categories: • Healthy food and groceries approved by the plan, such as fresh foods, dairy, dry goods, and beverages; • Medicare eligible over-the-counter (OTC) drugs or items such as first aid supplies, dental care, cold symptoms supplies and sun protection;	You receive $425 credit at the start of each quarter in January, April, July, and October, to use toward approved items. If the cost of the approved items exceeds the benefit limit of $425 per calendar

Services that are covered for you	**What you must pay** when you get these services
• MassHealth eligible OTC drugs or items, including those used daily for personal care, health or hygiene, such as shampoo, conditioner, deodorant and soap; and • Other approved items such as at-home COVID test kits, OTC hearing aids, and OTC Naloxone (or Narcan). Credits are loaded on the first day of each quarter (in January, April, July and October) and expire on the last day of each quarter (March 31, June 30, September 30 and December 31). You can use your **Instant Savings card** to pay for eligible items as described below. **Shop in stores:** Swipe your **Instant Savings card** at participating physical retailers including CVS Pharmacy, Dollar General, Walmart, Rite Aid, Walgreens, Stop & Shop, Star Market, and Family Dollar. For a complete list of participating retailers and locations, visit **thpmp.org/sco-otc**. Select "Locations" at the top of the homepage to search for participating retail locations near you. When you swipe your **Instant Savings card**, the cost of all eligible items will automatically be deducted up to the remaining balance on your card. You will be responsible for the costs of all items that are not eligible and/or for the costs of eligible items that exceed your remaining balance at the time of purchase. You can download and use the OTC Network® mobile app to keep track of your card balance and easily find eligible items when shopping at participating retailers. The OTC Network® mobile app is right at your fingertips, 24 hours a day, seven days a week. **Shop online:** Go to **thpmp.org/sco-otc**, log in using the number listed on your **Instant Savings card** and your nine-digit member ID number from your Tufts Health Plan Senior Care Options member ID card. You can search for eligible items, including national and store brands, by clicking on "Products" at the top of the homepage. To shop online, select "Locations" at the top	quarter, you are responsible for all additional costs. Any unused balance at the end of a calendar quarter will not roll over into the following calendar quarter.

Services that are covered for you	**What you must pay** when you get these services
of the homepage, then select "Online" on the left panel to see links to **Medline** and **Walmart.com**. Click on the link for the site where you will like to shop and follow the instructions below to shop on that site. • **Medline:** Order your items online at the Medline site or call **1-833-569-2330** Mon–Fri, 8 a.m.–7 p.m. ET, and a Medline representative will take your order. Call Tufts Health Plan Senior Care Options Member Services if you need a paper catalog mailed to you. Items ordered from Medline online or by phone will be delivered with no additional shipping fees approximately 2–5 business days after the order is received. • **Walmart.com:** Order your items online at **Walmart.com**. At checkout, select pay with card and enter your **Instant Savings card** number. Shipping fees may apply depending on your order size and are not covered by your OTC benefit. To avoid shipping fees, choose in-store pickup. *This benefit is covered by the plan under the Medicare and MassHealth (Medicaid) benefits.*	

Services that are covered for you	**What you must pay** when you get these services
Partial hospitalization services and Intensive outpatient services Partial hospitalization is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community behavioral health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community behavioral health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's or therapist's office but less intense than partial hospitalization. Short-term day behavioral health programming is available seven days per week consisting of therapeutically intensive acute treatment within a stable therapeutic environment and including daily psychiatric management. *This benefit is covered by the plan under the Medicare and MassHealth (Medicaid) benefits.*	You pay $0 for covered services.
Personal Care Attendant (PCA) Services A consumer-directed program that allows members to hire PCAs to help with Activities of Daily Living (ADLs) such as mobility/transfers, medications, bathing or grooming, dressing or undressing, range of motion exercises, eating, and toileting and with Instrumental Activities of Daily Living (IADLs) such as shopping, laundry, meal preparation, and/or housekeeping. Does not cover recreation, babysitting, vocational training, verbal prompting or cuing, or supervision. *This benefit is covered by the plan under the MassHealth (Medicaid) benefit.*	You pay $0 for covered services. Before you receive Personal Care Attendant (PCA) services, you must first discuss these services with your Plan Care Manager.

Services that are covered for you	**What you must pay** when you get these services
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your PCP/PCT, if your doctor orders it to see if you need medical treatment • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location • Telehealth services for members with a substance use disorder or co-occurring behavioral health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of behavioral health disorders if: o You have an in-person visit within 6 months prior to your first telehealth visit o You have an in-person visit every 12 months while receiving these telehealth services o Exceptions can be made to the above for certain circumstances • Telehealth services for behavioral health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**: o You're not a new patient **and** o The check-in isn't related to an office visit in the past 7 days **and** o The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment	You pay $0 for Medicare-covered services. You pay $0 for Medicare-covered telehealth services Before you receive specialist services you must first obtain a referral from your PCP.

Services that are covered for you	**What you must pay** when you get these services

• Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**:
  ○ You're not a new patient **and**
  ○ The evaluation isn't related to an office visit in the past 7 days **and**
  ○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment
• Consultation your doctor has with other doctors by phone, internet, or electronic health record
• Second opinion by another network provider prior to surgery
• Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)
• Annual Physical Exam (a more comprehensive examination than an annual wellness visit. Services will include the following: bodily systems examinations, such as heart, lung, head and neck, and neurological system/measurement and recording of vital signs such as blood pressure, heart rate, and respiratory rate; a complete prescription medication review; and a review of any recent hospitalizations). Covered once every calendar year
• Follow-up office visits following discharge from hospital, SNF, Community Behavioral Health Centers stay, outpatient observation, or partial hospitalization
• Additional telehealth services not covered by Medicare, including:
  ○ Primary Care Physician Services and Other Health Care Professionals (PAs & NPs)
  ○ Physician Specialist Services
  ○ Individual and Group Sessions for Behavioral Health Specialty Services
	You pay $0 for covered services.
	
	Before you receive additional telehealth services from a specialist you must first obtain a referral from your PCP.

Services that are covered for you	**What you must pay** when you get these services
○ Individual and Group Sessions for Psychiatric Services ○ Opioid Treatment Program Services ○ Observation Services ○ Individual and Group Sessions for Outpatient Substance Use Disorder ○ Kidney Disease Education Services ○ Diabetes Self-Management Training ○ Urgently Needed Services ○ Physical Therapy and Speech-Language Pathology Services • Additional telehealth coverage includes only synchronous audio and visual consultations with your physician using a HIPAA-compliant communication software • Additional telehealth services are covered with your existing providers from any location, or from any provider with a referral for a telemedicine visit from your PCP • You have the option of receiving these services either through an in-person visit or via telehealth. If you choose to receive one of these services via telehealth, you must use a network provider that currently offers the service via telehealth *This benefit is covered by the plan under the Medicare and MassHealth (Medicaid) benefits.*	

Services that are covered for you	**What you must pay** when you get these services
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs such as metabolic (diabetes), neurological or peripheral vascular disease (narrowing or blocking of the arteries carrying blood to the arms and legs) For foot care related to Diabetes, please see "Diabetes self-management training, diabetic services and supplies" in this benefits chart. *This benefit is covered by the plan under the Medicare and MassHealth (Medicaid) benefits.*	You pay $0 for covered services. Before you receive podiatry services you must first obtain a referral from your PCP.
Prostate cancer screening exams For men aged 50 and older, covered services include the following - once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for an annual PSA test.

Services that are covered for you	**What you must pay** when you get these services
Prosthetic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see Vision Care later in this section for more detail. Coverage also includes the evaluation, fabrication, and fitting of a prosthesis. Additional non-Medicare-covered items covered under MassHealth Standard (Medicaid): Surgical/compression stockings - 4 stockings per year Mastectomy sleeves - 2 pairs every 7 months *This benefit is covered by the plan under the Medicare and MassHealth (Medicaid) benefits.*	***Except in an emergency, prior authorization may be required before you obtain certain prosthetic devices and related supplies.*** You pay $0 for covered devices.
Medical Supplies Medically necessary items or other materials that are used once, and thrown away, or somehow used up. Includes but not limited to: catheters, gauze, surgical dressing supplies, bandages, sterile water, and tracheostomy supplies. *This benefit is covered by the plan under the Medicare and MassHealth (Medicaid) benefits.*	***Except in an emergency, prior authorization may be required before you obtain certain medical supplies.*** You pay $0 for covered supplies.

Services that are covered for you	**What you must pay** when you get these services
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	You pay $0 for covered services.
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are**: people aged 50-77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision-making visit or for the LDCT.

Services that are covered for you	**What you must pay** when you get these services
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. We also cover up to two individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office. *This benefit is covered by the plan under the Medicare and MassHealth (Medicaid) benefits.*	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.

Services that are covered for you	**What you must pay** when you get these services
Services to treat kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) • Laboratory • Tubing change and adaptor change • Hemodialysis; intermittent peritoneal dialysis; continuous cycling peritoneal dialysis; and continuous ambulatory peritoneal dialysis Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, Medicare Part B prescription drugs. *This benefit is covered by the plan under the Medicare and MassHealth (Medicaid) benefits.*	You pay $0 for covered services.

Services that are covered for you	**What you must pay** when you get these services
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, see Chapter 12 of this document. Skilled nursing facilities are sometimes called SNFs.) You are covered for up to 100 days each benefit period. No prior hospital stay is required. Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need because you are covered by MassHealth Standard (Medicaid). • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services	***Prior Authorization may be required before you receive skilled nursing services.*** You pay $0 for covered services. You are covered for up to 100 days each benefit period. No prior hospital stay is required. If you exhaust your Medicare benefit, you are still covered under MassHealth Standard (Medicaid). SCO members are followed throughout the continuum of health, including any time spent in a skilled nursing facility and/or long-term care facility. Tufts Health Plan Senior Care Options will direct you to selected facilities to best manage your specific needs while receiving care in an Institutional setting. Team members may include a Nurse Practitioner or Physician assigned, facility-based and community-based care managers, and specialists. You will work with your Primary Care Team (PCT) to select a facility from the identified options.

Services that are covered for you	**What you must pay** when you get these services
Skilled nursing facility (SNF) care (continued) Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to get your care from a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital *This benefit is covered by the plan under the Medicare and MassHealth (Medicaid) benefits.*	Exclusions include instances in which a close family member lives at a facility you are requesting or if you currently live in a facility and join our SCO program.

Services that are covered for you	**What you must pay** when you get these services
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period; however, you will pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits. We cover face-to-face individual and group tobacco cessation counseling and pharmacotherapy treatment, including nicotine replacement therapy (NRT). This is in addition to any services that are covered by Medicare. • Smoking cessation telephonic counseling is also available through the Massachusetts Tobacco Cessation and Prevention Program (MTCP). MTCP is a free, evidence-based stop-smoking service developed by the Massachusetts Department of Public Health. If you are ready to quit or are thinking about it, ask your doctor about the Massachusetts Tobacco Cessation and Prevention Program (MTCP), or visit www.mass.gov/take-the-first-step-toward-a-nicotine-free-life, or call 1-800-QUIT-NOW (1-800-784-8669). • Check your Tufts Health Plan Senior Care Options Formulary for covered smoking cessation agents. *This benefit is covered by the plan under the Medicare and MassHealth (Medicaid) benefits.*	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.

Services that are covered for you	**What you must pay** when you get these services
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD). Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	You pay $0 for covered services.
Transportation (medical appointments) Ambulance, taxi, and chair car transport for non-emergency medical appointments. To arrange transportation to medical appointments, call ModivCare at 1-855-251-7092 between the hours of 8 a.m. and 5 p.m. EST, Monday through Friday. TTY users should call 1-866-288-3113. Except in an emergency, requests for transportation to medical appointments must be made at least 2 business days in advance of the appointment, not counting the day of the call. *This benefit is covered by the plan under the MassHealth (Medicaid) benefits.*	You pay $0 for covered services. Services must be provided by the plan-approved transportation provider. Limitations may apply. For more information on this benefit, visit www.thpmp.org/sco, or call Member Services (phone numbers are located on the back cover of this book).

Services that are covered for you	**What you must pay** when you get these services
Transportation (non-medical purposes) Two round trips per month (up to 24 round trips per calendar year) is provided for non-medical purposes. Limit of 20 miles each way. To arrange transportation to non-medical appointments, call ModivCare at 1-855-251-7092 between the hours of 8 a.m. and 5 p.m. EST, Monday through Friday. TTY users should call 1-866-288-3113. Requests for transportation to non-medical appointments must be made at least 2 business days in advance of the appointment, not counting the day of the call. *This benefit is covered by the plan under the MassHealth (Medicaid) benefit.*	You pay $0 for covered services. Services must be provided by the plan-approved transportation provider. Limitations may apply. For more information on this benefit, visit www.thpmp.org/sco, or call Member Services (Phone numbers are located on the back cover of this book).
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but, given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. If it is unreasonable given your circumstances to immediately obtain the medical care from a network provider then your plan will cover the urgently needed services from a provider out-of-network. Services must be immediately needed and medically necessary. Examples of urgently needed services that the plan must cover out of network occur if: You are temporarily outside the service area of the plan and require medically needed immediate services for an unforeseen condition but it is not a medical emergency; or it is unreasonable given your circumstances to immediately obtain the medical care from a network provider. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. Your plan includes worldwide coverage for urgently needed care. *This benefit is covered by the plan under Medicare and MassHealth (Medicaid) benefits.*	You pay $0 for covered urgently needed services.

Services that are covered for you	**What you must pay** when you get these services
Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts Note: Please see additional information below for coverage of routine eye exams.	You pay $0 for each Medicare-covered outpatient visit for services to diagnose and/or treat a disease or condition of the eye.
• 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	You pay $0 for an annual glaucoma screening if you are at high risk. Before you receive services from an ophthalmologist for diagnosis and/or treatment of a medical condition of the eye, you must first obtain a referral from your PCP. No referral is required to see an optometrist, but you must use a provider in the EyeMed Vision Care network.
• For people with diabetes, screening for diabetic retinopathy is covered once per year	You pay $0 for an annual diabetic retinopathy screening. Before you receive services, you must first obtain a referral from your PCP.
• 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	You pay $0 for one pair of Medicare-covered standard eyeglasses with standard frames or contact lenses

Services that are covered for you	**What you must pay** when you get these services
purchase two eyeglasses after the second surgery.) Corrective lenses/frames (and replacements) needed after a cataract removal with a lens implant (Tints, anti-reflective coating, U-V lenses or oversize lenses are covered only when deemed medically necessary by the treating physician.) Note: Coverage includes standard fitting and follow up after insertion of contact lenses as follows: o Members will receive an initial contact lens fitting and up to 2 follow up visits are available once a comprehensive eye exam has been completed. o Member must complete the follow up within 45 calendar days of the fitting, and the fitting and follow up must be done by the same provider.	after cataract surgery when obtained from a provider in the EyeMed Vision Care network. You will pay any cost over the Medicare allowed charge if you purchase upgraded frames.
• One pair of standard therapeutic (prescription) eyeglasses every calendar year (includes one pair of standard frames and single vision, bifocal or trifocal lenses) or contact lenses for Keratoconus, Anisometropia, High Myopia, Aphakia, Congenital Aphakia, or Pseudoaphakia. Note: Coverage includes standard fitting and follow up after insertion of contact lenses as follows: o Members will receive an initial contact lens fitting and up to 2 follow up visits are available once a comprehensive eye exam has been completed. o Member must complete the follow up within 45 calendar days of the fitting, and the fitting and follow up must be done by the same provider.	You pay $0 for one pair of standard eyeglasses with standard frames or contact lenses for Keratoconus, Anisometropia, High Myopia, Aphakia, Congenital Aphakia, or Pseudoaphakia. You will pay any cost over the allowed charge. No referral is required for this service, but you must obtain covered eyewear from a provider in the EyeMed Vision Care network.
• One routine eye exam each calendar year	You pay $0 for one annual routine eye exam. No referral is required for an annual routine eye exam,

Services that are covered for you	**What you must pay** when you get these services
	but you must use a provider in the EyeMed Vision Care network. Eye refractions are not covered if billed separately from the routine eye exam. Refractions are not covered except when included and billed as a component of the routine eye exam.
• Eyewear Allowance (Lenses and Frames, or Contact Lenses) Routine eyeglasses (prescription lenses, frames, a combination of lenses and frames) and/or contact lenses up to the allowed calendar year amount. To contact EyeMed Vision Care if you have any questions about this benefit, call 1-866-591-1863. For members with hearing impairment, EyeMed provides a relay system to ensure that you can receive service whether you have a TDD/TTY enabled system or not. Using this system is really easy. Simply dial 711, ask the operator to contact EyeMed at 1-844-230-6498, and you will be assisted through a conference call between you, the 711 operator and a representative. *This benefit is covered by the plan under the Medicare and MassHealth (Medicaid) benefits.*	To access the routine eyewear benefit, you may purchase eyewear from any provider. If you choose an EyeMed Vision Care participating provider, you have the benefit of $300 per calendar year for eyeglasses (prescription lenses, frames, a combination of lenses and frames) and/or contact lenses, applied at the time of service, and would be responsible to pay for the balance. The EyeMed Vision Care provider will process the claim. If you use a non-participating provider, you would need to pay out of pocket and submit for reimbursement. You would be reimbursed up to $180 per calendar year for eyeglasses (prescription lenses, frames, a

Services that are covered for you	**What you must pay** when you get these services
	combination of lenses and frames) and/or contact lenses. You must file a claim with EyeMed Vision Care to get reimbursed. Call Member Services for the claim form. If the cost of the eyewear exceeds the benefit limit ($300 in the EyeMed Vision Care network, $180 for a non-participating provider), you are responsible for all additional charges. The plan provider for services, glasses or contacts for routine vision care may be different from the plan provider of services, glasses, or contacts to treat medical conditions. Call Member Services if you have questions about your vision benefits.
Welcome to Medicare preventive visit The plan covers the one-time Welcome to Medicare preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the Welcome to Medicare preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your Welcome to Medicare preventive visit.	There is no coinsurance, copayment, or deductible for the Welcome to Medicare preventive visit.

Services that are covered for you	**What you must pay** when you get these services
Wigs Wigs are covered for members who experience hair loss due to treatment for cancer. To obtain this reimbursement, please submit a member reimbursement form along with proof of payment and any additional information outlined on the form. Call Member Services to request a reimbursement form or go to our website www.thpmp.org/sco. Send the completed form with any required documents to the address shown on the form. If you have any questions, contact Member Services.	Plan covers up to $350 per year. To access the wig benefit, you may purchase the wig from any provider. If you choose a participating provider, you have the benefit of $350 per year applied at the time of service, and would be responsible to pay for the balance. If you use a non-participating provider, you would need to pay out of pocket and submit for reimbursement. You must file a claim with the plan to get reimbursed. Call Member Services for the claim form.

SECTION 3 What services are covered outside of Tufts Health Plan Senior Care Options?

Section 3.1 Services *not* covered by Tufts Health Plan Senior Care Options

There are no services available through Medicare or MassHealth (Medicaid) that Tufts Health Plan Senior Care Options does not cover.

SECTION 4 What services are not covered by the plan?

Section 4.1 Services *not* covered by the plan (exclusions)

This section tells you what services are “excluded”.

The chart below describes some services and items that aren't covered by the plan under any conditions or are covered by the plan only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you receive the excluded services at an emergency facility, the excluded services are still not covered and our plan will not pay for them. The only exception is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 8, Section 6.3 in this document.)

Services not covered by Medicare	**Not covered under any condition**	**Covered only under specific conditions**
Acupuncture		Up to 20 visits covered annually by Medicare. Additional services covered under your MassHealth (Medicaid) benefit, with prior authorization.
Cosmetic surgery or procedures		Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Custodial care Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.		Covered by the plan under the MassHealth (Medicaid) benefit.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.		• May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)
Fees charged for care by your immediate relatives or members of your household.		Covered by the plan under the MassHealth (Medicaid) benefit.
Full-time nursing care in your home.		May be covered by the plan under the MassHealth (Medicaid) benefit only when there are no alternative modes of care available. ***Prior authorization is required.***
Home-delivered meals		Covered by the plan under the MassHealth (Medicaid) benefit.
Homemaker services including basic household assistance, such as light housekeeping or light meal preparation.		Covered by the plan under the MassHealth (Medicaid) benefit.
Naturopath services (uses natural or alternative treatments).	**Not covered under any condition**	
Non-routine dental care		• Dental care required to treat illness or injury may be covered as inpatient or outpatient care. Additional services covered under your MassHealth (Medicaid) benefit.
Orthopedic shoes or supportive devices for the feet		• Shoes that are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease. Orthopedic or therapeutic shoes for people with diabetic foot disease.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	**Not covered under any condition**	
Private room in a hospital.		• Covered only when medically necessary.
Reversal of sterilization procedures and/or non-prescription contraceptive supplies.	**Not covered under any condition**	
Routine chiropractic care		• Manual manipulation of the spine to correct a subluxation is covered. Additional services covered under your MassHealth (Medicaid) benefit.
Routine dental care, such as cleanings, fillings or dentures.		Covered by the plan under your MassHealth (Medicaid) benefit.
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids.		• Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery.
Routine foot care		• Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes). Services covered under your MassHealth (Medicaid) benefit when medically necessary.
Routine hearing exams, hearing aids, or exams to fit hearing aids.		• Diagnostic hearing exams are covered under Medicare. Hearing aids and fittings are covered under your MassHealth Standard (Medicaid) benefits. • OTC hearing aids are covered under over-the-counter (OTC) benefit.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services considered not reasonable and necessary, according to Original Medicare standards		Covered only under specific conditions: Services considered not reasonable and necessary, according to the standards of Original Medicare, are not covered, unless these services are listed by the plan as covered services or are covered by the plan under MassHealth (Medicaid) benefits or are determined to be necessary based upon the individualized care plan.

CHAPTER 5:
Using the plan's coverage for Part D prescription drugs

How can you get information about your drug costs

Because you are eligible for MassHealth Standard (Medicaid), you qualify for and are getting "Extra Help" from Medicare to pay for your prescription drug plan costs. Because you are in the "Extra Help" program, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.**

SECTION 1 Introduction

This chapter **explains rules for using your coverage for Part D drugs**. Please see Chapter 4 for Medicare Part B drug benefits and hospice drug benefits.

In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your MassHealth Standard (Medicaid) benefits. The Over-the-Counter (OTC) "Drug List" tells you how to find out about your MassHealth Standard (Medicaid) drug coverage.

Section 1.1 Basic rules for the plan's Part D drug coverage

The plan will generally cover your drugs as long as you follow these basic rules:

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription which must be valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription. (See Section 2, *Fill your prescriptions at a network pharmacy or through the plan's mail-order service*.)
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Drug List" for short). (See Section 3, *Your drugs need to be on the plan's "Drug List"*.)
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain references. (See Section 3 for more information about a medically accepted indication.)

SECTION 2 Fill your prescription at a network pharmacy or through the plan's mail-order service

Section 2.1 Use a network pharmacy

In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies. (See Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term covered drugs means all of the Part D prescription drugs that are on the plan's "Drug List".

Section 2.2 Network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Provider and Pharmacy Directory*, visit our website (www.thpmp.org/sco), and/or call Member Services.

You may go to any of our network pharmacies. Some of our network pharmacies provide preferred cost sharing, which may be lower than the cost sharing at a pharmacy that offers standard cost sharing. The *Provider and Pharmacy Directory* will tell you which of the network pharmacies offer preferred cost sharing. Contact us to find out more about how your out-of-pocket costs could vary for different drugs.

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another pharmacy in your area, you can get help from Member Services or use the *Provider and Pharmacy Directory*. You can also find information on our website at www.thpmp.org/sco.

What if you need a specialized pharmacy?

Some prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy. Our plan will cover home infusion therapy if:
  - Your prescription drug is on our plan's formulary or a formulary exception has been granted for your prescription,
  - Your prescription drug is not otherwise covered under our plan's medical benefit,
  - Our plan has approved your prescription for home infusion therapy, and
  - Your prescription is written by an authorized prescriber.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Member Services.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.

- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (**Note:** This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Provider and Pharmacy Directory* or call Member Services.

Section 2.3 Using the plan's mail-order service

For certain kinds of drugs, you can use the plan's network mail-order service. Generally, the drugs provided through mail order are drugs that you take on a regular basis, for a chronic or long-term medical condition.

Our plan's mail-order service requires you to order ***at least*** **a 30-day supply of the drug and** ***no more than*** **a 90-day supply**.

To get order forms and information about filling your prescriptions by mail call Member Services (phone numbers are listed on the back cover of this booklet).

Usually a mail-order pharmacy order will be delivered to you in no more than 15 days. However, sometimes your mail-order may be delayed. If your order is delayed, please call Member Services (phone numbers are printed on the back cover of this booklet) during business hours and we will allow you to fill a partial supply of the medication at a network retail pharmacy.

> **New prescriptions the pharmacy receives directly from your doctor's office**.
> After the pharmacy receives a prescription from a health care provider, it will contact you to see if you want the medication filled immediately or at a later time. It is important that you respond each time you are contacted by the pharmacy, to let them know whether to ship, delay, or stop the new prescription.

Refills on mail-order prescriptions. For refills, please contact your pharmacy 15 days before your current prescription will run out to make sure your next order is shipped to you in time.

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you. Please call OptumRx Customer Service toll-free at 1-800-510-4817 (TTY 711) to provide your preferred contact information. Hours of operation are 24 hours per day, 7 days a week.

Section 2.4 How can you get a long-term supply of drugs?

The plan offers two ways to get a long-term supply (also called an extended supply) of maintenance drugs on our plan's "Drug List". (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs. Your *Provider and Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Member Services for more information.
2. You may also receive maintenance drugs through our mail-order program. Please see Section 2.3 for more information.

Section 2.5 When can you use a pharmacy that is not in the plan's network?

Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. To help you, we have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. **Please check first with Member Services** to see if there is a network pharmacy nearby. You will most likely be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- **Medical Emergencies**
  - There is no coverage at out-of-network pharmacies. However, if you pay out of pocket for a prescription related to care for a medical emergency or urgently needed care you can ask us to reimburse you for our share of the cost by submitting a paper claim form. (See details below under *"How do you ask for reimbursement from the plan".*) If you find yourself in this situation you can also contact Member Services (phone numbers are located on the back cover of this book).
- **When you travel or are away from the plan's service area**
  - If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. You may be able to order your prescription drugs ahead of time through our network mail order pharmacy service or through a retail network pharmacy.
  - If you are traveling within the U.S. but outside of the plan's service area and you become ill or if you lose or run out of your prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy if you follow all other coverage rules identified within this document and a network pharmacy is not available. There is no coverage at out-of-network pharmacies. However, if you pay out of pocket for a prescription related to care for a medical emergency or urgently needed care you can ask us to reimburse you for our share of the cost by submitting a paper claim form. (See details below under *"How do you ask for reimbursement from*

the plan".) If you find yourself in this situation you can also contact Member Services. (Phone numbers are located on the back cover of this book.)

- Prior to filling your prescriptions at an out-of-network pharmacy, call Member Services to find out if there is a network pharmacy in the area where you are traveling. Our pharmacy network is nationwide. If there are no network pharmacies in that area, you may be able to make arrangements for you to get your prescriptions from an out-of-network pharmacy.

- **Other times you can get your prescription covered if you go to an out-of-network pharmacy**
  - We will cover your prescription at an out-of-network pharmacy if at least one of the following applies:
    - If you are unable to get a covered drug in a timely manner within our service area because there are no network pharmacies within a reasonable driving distance that provide 24-hour service.
    - If you are trying to fill a covered prescription drug that is not regularly stocked at an eligible network retail or mail order pharmacy (these drugs include orphan drugs or other specialty pharmaceuticals).
    - You can ask us to reimburse you the cost by submitting a claim form.

In these situations, **please check first with** to see if there is a network pharmacy nearby. (Phone numbers for Member Services are printed on the back cover of this booklet.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

How do you ask for reimbursement from the plan?

SCO members do not have a cost to covered services.

If you must use an out-of-network pharmacy, you will generally have to pay the full cost at the time you fill your prescription. You can ask us to reimburse you. (Chapter 6, Section 2.1 explains how to ask the plan to pay you back.)

SECTION 3 Your drugs need to be on the plan's "Drug List"

Section 3.1 The "Drug List" tells which Part D drugs are covered

The plan has a *List of Covered Drugs (Formulary).* In this *Evidence of Coverage*, **we call it the "Drug List" for short.**

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare.

The "Drug List" includes the drugs covered under Medicare Part D. In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your MassHealth Standard (Medicaid) benefits. The Over-the-Counter (OTC) "Drug List" tells you how to find out about your MassHealth Standard (Medicaid) drug coverage.

We will generally cover a drug on the plan's "Drug List" as long as you follow the other coverage rules explained in this chapter and the use of the drug is a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- Approved by the Food and Drug Administration for the diagnosis or condition for which it is being prescribed.)
- *or* -- Supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

Certain drugs may be covered for some medical conditions, but are considered non-formulary for other medical conditions. These drugs will be identified on our "Drug List" and in Medicare Plan Finder, along with the specific medical conditions that they cover.

The "Drug List" includes brand name drugs and generic drugs.

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Brand name drugs that are more complex than typical drugs (for example, drugs that are based on a protein) are called biological products. On the "Drug List", when we refer to "drugs," this could mean a drug or a biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Generally, generics work just as well as the brand name drug and usually cost less. There are generic drug substitutes available for many brand name drugs.

Over-the-Counter Drugs

Our plan also covers certain over-the-counter drugs. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. For more information, call Member Services.

What is *not* on the "Drug List"?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more information about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on the "Drug List". In some cases, you may be able to obtain a drug that is not on the "Drug List". For more information, please see Chapter 8.

- The Over-the-Counter (OTC) "Drug List" tells you how to find out about your MassHealth Standard (Medicaid) drug coverage.

Section 3.2 How can you find out if a specific drug is on the "Drug List"?

You have 4 ways to find out:

1. Check the most recent "Drug List" we provided electronically.
2. Visit the plan's website (www.thpmp.org/sco). The "Drug List" on the website is always the most current.
3. Call Member Services to find out if a particular drug is on the plan's "Drug List" or to ask for a copy of the list.
4. Use the plan's "Real-Time Benefit Tool" (www.thpmp.org/sco) or by calling Member Services). With this tool you can search for drugs on the "Drug List" to see an estimate of what you will pay and if there are alternative drugs on the "Drug List" that could treat the same condition.

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective way. To find out if any of these restrictions apply to a drug you take or want to take, check the "Drug List". If a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option.

Please note that sometimes a drug may appear more than once in our "Drug List". This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your health care provider, and different restrictions or cost sharing may apply to the different versions of the drug (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

Section 4.2 What kinds of restrictions?

The sections below tell you more about the types of restrictions we use for certain drugs.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. Contact Member Services to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the

restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 8.)

Restricting brand name drugs when a generic version is available

Generally, a generic drug works the same as a brand name drug and usually costs less. **When a generic version of a brand name drug is available, our network pharmacies will provide you the generic version instead of the brand name drug.** However, if your provider has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug. (Your share of the cost may be greater for the brand name drug than for the generic drug.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called **prior authorization**. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition and Drug A is less costly, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called **step therapy**.

Quantity limits

For certain drugs, we limit how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

SECTION 5 What if one of your drugs is not covered in the way you'd like it to be covered?

Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered

There are situations where there is a prescription drug you are taking, or one that you and your provider think you should be taking, that is not on our formulary or is on our formulary with restrictions. For example:

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.

- The drug is covered, but there are extra rules or restrictions on coverage for that drug, as explained in Section 4.

- There are things you can do if your drug is not covered in the way that you'd like it to be covered.
- If your drug is not on the "Drug List" or if your drug is restricted, go to Section 5.2 to learn what you can do.

Section 5.2 What can you do if your drug is not on the "Drug List" or if the drug is restricted in some way?

If your drug is not on the "Drug List" or is restricted, here are options:

- You may be able to get a temporary supply of the drug.
- You can change to another drug.
- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, the plan must provide a temporary supply of a drug that you are already taking. This temporary supply gives you time to talk with your provider about the change in coverage and decide what to do.

To be eligible for a temporary supply, the drug you have been taking **must no longer be on the plan's "Drug List"** OR **is now restricted in some way**.

- **If you are a new member,** we will cover a temporary supply of your drug during the first **90 days** of your membership in the plan.
- **If you were in the plan last year,** we will cover a temporary supply of your drug during the first **90 days** of the calendar year.
- This temporary supply will be for a maximum of **30-day** supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of 30 days of medication. The prescription must be filled at a network pharmacy. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For those members who have been in the plan for more than 90 days and reside in a long-term care facility and need a supply right away:**

  We will cover one 31-day supply emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.

As a current member, if you are in a long-term facility and if you experience an unplanned drug change due to a change in level of care, you can request that we approve a one-time, temporary

fill of the non-covered medication to allow you time to discuss a transition plan with your physician. Your physician can also request an exception to coverage for the non-covered drug based on review for medical necessity following the standard exception process outlined previously. The temporary "first fill" will generally be up to a 31-day supply but may be extended to allow you and your physician time to manage the complexities of multiple medications or when special circumstances warrant. You or your personal representative can request a temporary prescription fill by calling the Tufts Health Plan Senior Care Options Member Services department (phone numbers are printed on the back cover of this booklet).

- Please note that our transition policy applies to both "Part D drugs" and covered Over-the-Counter (OTC) drugs purchased at a network pharmacy. The transition policy can't be used to buy a Part D drug or OTC drug out of network, unless you qualify for out-of-network access.

For questions about a temporary supply, call Member Services.

During the time when you are using a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You have two options:

1) You can change to another drug

Talk with your provider about whether there is a different drug covered by the plan that may work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

2) You can ask for an exception

You and your provider can ask the plan to make an exception and cover the drug in the way you would like it covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception. For example, you can ask the plan to cover a drug even though it is not on the plan's "Drug List". Or you can ask the plan to make an exception and cover the drug without restrictions.

If you are a current member and a drug you are taking will be removed from the formulary or restricted in some way for next year, we will tell you about any change prior to the new year. You can ask for an exception before next year and we will give you an answer within 72 hours after we receive your request (or your prescriber's supporting statement). If we approve your request, we will authorize the coverage before the change takes effect.

If you and your provider want to ask for an exception, Chapter 8, Section 7.4 tells you what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

SECTION 6 What if your coverage changes for one of your drugs?

Section 6.1 The "Drug List" can change during the year

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the plan can make some changes to the "Drug List". For example, the plan might:

- **Add or remove drugs from the "Drug List"**.
- **Add or remove a restriction on coverage for a drug**.
- **Replace a brand name drug with a generic version of the drug**.

We must follow Medicare requirements before we change the plan's "Drug List".

Section 6.2 What happens if coverage changes for a drug you are taking?

Information on changes to drug coverage

When changes to the "Drug List" occur, we post information on our website about those changes. We also update our online "Drug List" on a regularly scheduled basis. Below we point out the times that you would get direct notice if changes were made to a drug that you are taking.

Changes to your drug coverage that affect you during the current plan year

- **A new generic drug replaces a brand name drug on the "Drug List" (or we change the cost-sharing tier or add new restrictions to the brand name drug or both)**
    - We may immediately remove a brand name drug on our "Drug List" if we are replacing it with a newly approved generic version of the same drug. The generic drug will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. We may decide to keep the brand name drug on our "Drug List", but immediately move it to a higher cost-sharing tier or add new restrictions or both when the new generic is added.
    - We may not tell you in advance before we make that change—even if you are currently taking the brand name drug. If you are taking the brand name drug at the time we make the change, we will provide you with information about the specific change(s). This will also include information on the steps you may take to request an exception to cover the brand name drug. You may not get this notice before we make the change.

- You or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 8.

- **Unsafe drugs and other drugs on the "Drug List" that are withdrawn from the market**
  - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the "Drug List". If you are taking that drug, we will tell you right away.
  - Your prescriber will also know about this change, and can work with you to find another drug for your condition.

Other changes to drugs on the "Drug List"

- We may make other changes once the year has started that affect drugs you are taking. For example, we might add a generic drug that is not new to the market to replace a brand name drug on the "Drug List" or change the cost-sharing tier or add new restrictions to the brand name drug or both. We also might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
- For these changes, we must give you at least 30 days' advance notice of the change or give you notice of the change and a 30-day refill of the drug you are taking at a network pharmacy.
- After you receive notice of the change, you should work with your prescriber to switch to a different drug that we cover or to satisfy any new restrictions on the drug you are taking.
- You or your prescriber can ask us to make an exception and continue to cover the drug for you. For information on how to ask for an exception, see Chapter 8.

Changes to the "Drug List" that do not affect you during this plan year

We may make certain changes to the "Drug List" that are not described above. In these cases, the change will not apply to you if you are taking the drug when the change is made; however, these changes will likely affect you starting January 1 of the next plan year if you stay in the same plan.

In general, changes that will not affect you during the current plan year are:

- We put a new restriction on the use of your drug.
- We remove your drug from the "Drug List".

If any of these changes happen for a drug you are taking (except for market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), then the change won't affect your use or what you pay as your share of the cost until January 1 of the next

year. Until that date, you probably won't see any increase in your payments or any added restrictions to your use of the drug.

We will not tell you about these types of changes directly during the current plan year. You will need to check the "Drug List" for the next plan year (when the list is available during the open enrollment period) to see if there are any changes to the drugs you are taking that will impact you during the next plan year.

SECTION 7 What types of drugs are *not* covered by the plan?

Section 7.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are excluded. This means neither Medicare nor MassHealth Standard (Medicaid) pays for these drugs.

If you appeal and the requested drug is found not to be excluded under Part D, we will pay for or cover it. (For information about appealing a decision, go to Chapter 8.) If the drug excluded by our plan is also excluded by MassHealth (Medicaid), you must pay for it yourself.

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States or its territories.
- Our plan usually cannot cover off-label use. Off-label use is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
- Coverage for off-label use is allowed only when the use is supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

In addition, by law, the following categories of drugs listed below are not covered by Medicare. However, some of these drugs may be covered for you under your MassHealth Standard (Medicaid) drug coverage as indicated below.

- Non-prescription drugs (also called over-the-counter drugs). Certain over-the-counter drugs are covered for you under your MassHealth Standard (Medicaid) drug coverage.
- Drugs used for the relief of cough or cold symptoms. Certain drugs for relief of cough or cold symptoms are covered for you under your MassHealth Standard (Medicaid) drug coverage.
- Drugs used for cosmetic purposes or to promote hair growth

- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations. Certain vitamins and mineral products are covered for you under your MassHealth Standard (Medicaid) drug coverage.
- Drugs used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

If you are receiving "Extra Help" to pay for your prescriptions, the "Extra Help" program will not pay for the drugs not normally covered. However, if you have drug coverage through MassHealth (Medicaid), your Massachusetts Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your MassHealth (Medicaid) program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

SECTION 8 Filling a prescription

Section 8.1 Provide your membership information

To fill your prescription, provide your plan membership information, which can be found on your membership card, at the network pharmacy you choose. The network pharmacy will automatically bill the plan for your drug.

Section 8.2 What if you don't have your membership information with you?

If you don't have your plan membership information with you when you fill your prescription, you or the pharmacy can call the plan to get the necessary information, or you can ask the pharmacy to look up your plan enrollment information.

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up**. (You can then **ask us to reimburse you**. See Chapter 6, Section 2 for information about how to ask the plan for reimbursement.)

SECTION 9 Part D drug coverage in special situations

Section 9.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?

If you are admitted to a hospital or to a skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, the plan will cover your prescription drugs as long as the drugs meet all of our rules for coverage described in this Chapter.

Section 9.2 What if you're a resident in a long-term care (LTC) facility?

Usually, a long-term care (LTC) facility (such as a nursing home) has its own pharmacy, or uses a pharmacy that supplies drugs for all of its residents. If you are a resident of an LTC facility, you may get your prescription drugs through the facility's pharmacy or the one it uses, as long as it is part of our network.

Check your *Pharmacy Directory* to find out if your LTC facility's pharmacy or the one that it uses is part of our network. If it isn't, or if you need more information or assistance, please contact Member Services. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies.

What if you're a resident in a long-term care (LTC) facility and need a drug that is not on our "Drug List" or is restricted in some way?

Please refer to Section 5.2 about a temporary or emergency supply.

Section 9.3 What if you're in Medicare-certified hospice?

Hospice and our plan do not cover the same drug at the same time. If you are enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea drugs, laxatives, pain medication or anti-anxiety drugs) that are not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover your drugs as explained in this document. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, bring documentation to the pharmacy to verify your revocation or discharge.

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

- Possible medication errors
- Drugs that may not be necessary because you are taking another drug to treat the same condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions for drugs that have ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you are taking
- Unsafe amounts of opioid pain medications

If we see a possible problem in your use of medications, we will work with your provider to correct the problem.

Section 10.2 Drug Management Program (DMP) to help members safely use their opioid medications

We have a program that helps make sure members safely use prescription opioids and other medications that are frequently used inappropriately by those with substance use disorder. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several doctors or pharmacies, or if you had a recent opioid overdose, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid medications may not be safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may be:

- Requiring you to get all your prescriptions for opioid medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid medications from a certain doctor(s)
- Limiting the amount of opioid medications we will cover for you

If we plan on limiting how you may get these medications or how much you can get, we will send you a letter in advance. The letter will tell you if we limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific doctor or pharmacy. You will have an opportunity to tell us which doctors or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we will send you another letter confirming the limitation. If you think we made a mistake or you disagree with our decision or with the limitation, you and your prescriber have the right to appeal. If you appeal, we will review your case and give you a new decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we will automatically send your case to an independent reviewer outside of our plan. See Chapter 8 for information about how to ask for an appeal.

You will not be placed in our DMP if you have certain medical conditions, such as active cancer-related pain or sickle cell disease, you are receiving hospice, palliative, or end-of-life care, or live in a long-term care facility.

Section 10.3 Medication Therapy Management (MTM) program to help members manage their medications

We have a program that can help our members with complex health needs. Our program is called a Medication Therapy Management (MTM) program. This program is voluntary and free. A team of pharmacists and doctors developed the program for us to help make sure that our members get the most benefit from the drugs they take.

Some members who take medications for different medical conditions and have high drug costs, or are in a DMP to help members use their opioids safely, may be able to get services through an MTM program. Because you get assistance from MassHealth (Medicaid), you have no cost share for covered services. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all your medications. During the review, you can talk about your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take, and when and why you take them. In addition, members in the MTM program will receive information on the safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your recommended to-do list and medication list. Bring the summary with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, keep your medication list up to date and with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you. If you have any questions about this program, please contact Member Services.

SECTION 11 We send you reports that explain payments for your drugs and which payment stage you are in

Section 11.1 We send you a monthly summary called the "Part D Explanation of Benefits" (the "Part D EOB")

Note: The following section may not apply to you. Because you get assistance from MassHealth (Medicaid), you have no out-of-pocket costs for covered Part D prescription drugs.

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your "**out-of-pocket**" cost.
- We keep track of your "**total drug costs**." This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.

Our plan will prepare a written summary called the *Part D Explanation of Benefits* (it is sometimes called the "Part D EOB") when you have had one or more prescriptions filled through the plan during the previous month. The Part D EOB provides more information about the drugs you take, such as increases in price and other drugs with lower cost-sharing that may be available. You should consult with your prescriber about these lower cost options. The Part D EOB includes:

- **Information for that month**. This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called "year-to-date" information. It shows you the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This information will display the total drug price, and any percentage change from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This will include information about other drugs with lower cost-sharing for each prescription claim that may be available.

Section 11.2 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. Because you get assistance from MassHealth (Medicaid), your cost for covered drugs is $0. (If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2 of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
    - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.
    - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
    - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive a *Part D Explanation of Benefits* (a "Part D EOB") in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call us at Member Services (phone numbers are printed on the back cover of this booklet). Be sure to keep these reports. They are an important record of your drug expenses.

CHAPTER 6:

Asking us to pay a bill you have received for covered medical services or drugs – You are not responsible for a cost to covered services

SECTION 1 Situations in which you should ask us to pay for your covered services or drugs

Our network providers bill the plan directly for your covered services and drugs – you should not receive a bill for covered services or drugs. If you get a bill for medical care or drugs you have received, you should send this bill to us so that we can pay it. When you send us the bill, we will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

If you have already paid for a Medicare service or item covered by the plan, you can ask our plan to pay you back (paying you back is often called reimbursing you). It is your right to be paid back by our plan whenever you've paid for medical services or drugs that are covered by our plan. Because you get assistance from MassHealth (Medicaid), you have no cost share for covered services. There may be deadlines that you must meet to get paid back. Please see Section 2 of this chapter. When you send us a bill you have already paid, we will look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we will pay you back for the services or drugs. Submit your bill to us within 12 months of the date you received the service or drug.

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

Here are examples of situations in which you may need to ask our plan to pay you back or to pay a bill you have received:

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

You can receive emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases, ask the provider to bill the plan.

- If you pay the entire amount yourself at the time you receive the care, ask us to pay you back. Send us the bill, along with documentation of any payments you have made.
- You may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
    - If the provider is owed anything, we will pay the provider directly.
    - If you have already paid for the service, we will pay you back.

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

Network providers should always bill the plan directly. But sometimes they make mistakes, and ask you to pay for your services.

- Whenever you get a bill from a network provider, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, send us the bill along with documentation of any payment you have made. You should ask us to pay you back for your covered services.

3. If you are retroactively enrolled in our plan

Sometimes a person's enrollment in the plan is retroactive. (This means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered services or drugs after your enrollment date, you can ask us to pay you back. You will need to submit paperwork such as receipts and bills for us to handle the reimbursement.

4. When you use an out-of-network pharmacy to get a prescription filled

If you go to an out-of-network pharmacy, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription.

Save your receipt and send a copy to us when you ask us to pay you back. Remember that we only cover out-of-network pharmacies in limited circumstances. See Chapter 5, Section 2.5 for a discussion of these circumstances.

5. When you pay the full cost for a prescription because you don't have your plan membership card with you

If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself. Save your receipt and send a copy to us when you ask us to pay you back.

6. When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on the plan's "Drug List"; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for the drug.

When you send us a request for payment, we will review your request and decide whether the service or drug should be covered. This is called making a coverage decision. If we decide it should be covered, we will pay for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 8 of this document has information about how to make an appeal.

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

You may request us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website (www.thpmp.org/sco) or call Member Services and ask for the form.

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

Tufts Health Plan Senior Care Options
Claims Department
P.O. Box 518
Canton, MA 02021-1166

Part D Prescription Payment Requests:
OptumRx Claims Department
P.O. Box 650287
Dallas, TX 75265-0287

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

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

Section 3.1 We check to see whether we should cover the service or drug

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

- If we decide that the medical care or drug is covered and you followed all the rules, we will pay for the service. If you have already paid for the service or drug, we will mail your reimbursement to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider.
- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we will not pay for the care or drug. We will send you a letter explaining the reasons why we are not sending the payment and your rights to appeal that decision.

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

If you think we have made a mistake in turning down your request for payment or the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 8 of this document.

CHAPTER 7:
Your rights and responsibilities

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

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

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

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

Our plan has people available to answer questions from the disabled and members who require translation services, in multiple languages. We also offer free interpreter services and can give you the information in braille, in large print, or other alternate formats at no cost if you need it.

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

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

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with our Civil Rights Coordinator (contact information can be found in Chapter 10, Section 5). You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

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

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

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

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

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

Si tiene inconvenientes para obtener información de nuestro plan en un formato que le resulte accesible y apropiado, llame para presentar una queja ante nuestro Coordinador de Derechos Civiles (puede encontrar la información de contacto en el Capítulo 10, Sección 5). También puede presentar un reclamo ante Medicare si llama al 1-800-MEDICARE (1-800-633-4227) o directamente en la Oficina de Derechos Civiles, al 1-800-368-1019 o TTY 1-800-537-7697.

Section 1.2 We must treat you with fairness and respect at all times

Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, ethnicity, national origin, religion, gender, age, behavioral or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. You

have the right to be treated with respect and with consideration for your dignity. Under the rules of the plan, you have the right to be free from any kind of physical restraint or seclusion that would be used as a means of coercion, force, discipline, convenience, or retaliation.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Member Services (phone numbers are printed on the back cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

Section 1.3 You have the right to be free of abuse, neglect, and exploitation

You have the right to be free of abuse, neglect, and exploitation. Federal and state laws protect your health and well-being. If you think you are experiencing a situation where you are the recipient of intended or unintended abuse, neglect, or exploitation, please contact your Care Manager, another member of your Primary Care Team or Member Services (phone numbers are printed on the back of this book). If you feel that you are experiencing an instance of abuse, neglect, or exploitation and it is an emergency, please call 911.

Section 1.4 We must ensure that you get timely access to your covered services and drugs

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

You have the right to get appointments and covered services from the plan's network of providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays. As a new enrollee you have the right to receive access to services consistent with the access you previously had, and you are permitted to retain your current provider for up to *90 days* if that provider is not in our network, or until you are assessed and a plan of care is implemented, whichever is sooner.

Our plan strives to meet the network access standards specified in our contract with MassHealth to ensure that you get the care you need within a reasonable time. If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 8 tells what you can do.

Section 1.5 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your personal health information includes the **personal information** you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- You have rights related to your information and controlling how your health information is used. We give you a written notice, called a *Notice of Privacy Practice*, that talks about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you or someone you have given legal power to make decisions for you first.*
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
    - We are required to release health information to government agencies that are checking on quality of care.
    - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

You can see the information in your records and know how it has been shared with others

The Centralized Enrollee Record (CER) contains centralized and comprehensive documentation, including information relevant to each Enrollee's general health and well-being, as well as clinical information concerning illnesses and chronic medical conditions.

Information contained in the CER is available to members, their authorized representatives, and providers through Member Services (phone numbers are printed on the back cover of this booklet).

Persons other than treating providers who request information must provide written authorization from the member allowing the release of medical information.

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Member Services.

Section 1.6 We must give you information about the plan, its network of providers, and your covered services

As a member of Tufts Health Plan Senior Care Options, you have the right to get several kinds of information from us.

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

- **Information about our plan**. This includes, for example, information about the plan's financial condition.
- **Information about our network providers and pharmacies.** You have the right to get information about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services. Chapters 5 and 6 provide information about Part D prescription drug coverage.
- Family planning services at any contracted family planning provider are covered. You may choose any provider in our network or a MassHealth provider to get certain family planning services. This means that you can pick any doctor, clinic, hospital, pharmacy, or family-planning office. Call Member Services (phone numbers are printed on the back cover of this booklet) if you need help finding a provider for family planning services.
- **Information about why something is not covered and what you can do about it.** Chapter 8 provides information on asking for a written explanation on why a medical

service or Part D drug is not covered or if your coverage is restricted. Chapter 8 also provides information on asking us to change a decision, also called an appeal.

Section 1.7 We must support your right to make decisions about your care

You have the right to know your treatment options and participate in decisions about your health care

You have the right to get full information from your doctors and other health care providers. Your providers must explain your medical condition and your treatment choices *in a way that you can understand*.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** You have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no.**" You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called **advance directives**. There are different types of advance directives and different names

for them. Documents called **living will** and **power of attorney for health care** are examples of advance directives.

If you want to use an advance directive to give your instructions, here is what to do:

- **Get the form.** You can get an advance directive form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Member Services to ask for the forms.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

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

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

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with KEPRO (Massachusetts's Quality Improvement Organization) at 1-888-319-8452 (TTY: 711).

Section 1.8 You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems, concerns, or complaints and need to request coverage, or make an appeal, Chapter 8 of this document tells what you can do. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly**.

Section 1.9 What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights

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

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you are having:

- You can **call Member Services**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).
- You can also call **My Ombudsman**. For details about this organization and how to contact it, go to Chapter 2, Section 6.

Section 1.10 How to get more information about your rights

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

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

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

ESTATE RECOVERY AWARENESS

MassHealth is required by federal law to recover money from the estates of certain MassHealth members who are age 55 years or older, and who are any age and are receiving long-term care in a nursing home or other medical institution. For more information about MassHealth estate recovery, please visit www.mass.gov/estaterecovery.

INFORME PARA LA RECUPERACIÓN DE LOS BIENES

MassHealth está obligado por ley federal a recuperar el dinero de los bienes de ciertos miembros de MassHealth de 55 años en adelante, y de los que tengan cualquier edad y estén recibiendo atención a largo plazo en un hogar para adultos mayores u otra institución médica. Para obtener más información sobre la recuperación de los bienes con MassHealth, visite www.mass.gov/estaterecovery.

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

- **Get familiar with your covered services and the rules you must follow to get these covered services**. Use this Evidence of Coverage to learn what is covered for you and the rules you need to follow to get your covered services.
    - Chapters 3 and 4 give the details about your medical services.
    - Chapters 5 and 6 give the details about your Part D prescription drug coverage.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
    - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
    - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
    - If you have any questions, be sure to ask and get an answer you can understand.

- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe**. As a plan member, you are responsible for these payments:
    - You must continue to pay your Medicare premiums to remain a member of the plan.
    - If you are required to pay the extra amount for Part D because of your higher income (as reported on your last tax return), you must continue to pay the extra amount directly to the government to remain a member of the plan.
- **If you move *within* our service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* of our plan service area, you cannot remain a member of our plan.**
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

SECTION 3 How we help you receive Quality Care

Section 3.1 Medical management program

Our Medical Management (MM) Program helps arrange for members to receive quality health care in an appropriate treatment setting. MM refers to the process by which Tufts Health Plan or a health care provider authorizes coverage for health care procedures or treatments. Coverage decisions are based on medical necessity guidelines utilizing Medicare and MassHealth Standard (Medicaid) coverage guidelines and the appropriateness of care, service, and setting.

You have the right to a candid discussion with a member of your Primary Care Team about appropriate or medically necessary treatment options, regardless of cost or benefit coverage.

Tufts Health Plan's Medical Management Program follows all Medicare and MassHealth Standard (Medicaid) Coverage Guidelines.

CHAPTER 8:

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

SECTION 1 Introduction

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

This chapter explains the processes for handling problems and concerns. The process you use to handle your problem depends on the type of problem you are having:

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

Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

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

Section 1.2 What about the legal terms?

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand. To make things easier, this chapter:

- Uses simpler words in place of certain legal terms. For example, this chapter generally says making a complaint rather than filing a grievance, coverage decision rather than integrated organization determination or coverage determination or at-risk determination, and independent review organization instead of Independent Review Entity.
- It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms. Knowing which terms to use will help you communicate more accurately to get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 Where to get more information and personalized assistance

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

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers and website URLs in Chapter 2, Section 3 of this document.

Medicare

You can also contact Medicare to get help. To contact Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You also can visit the Medicare website (www.medicare.gov).

You can get help and information from MassHealth (Medicaid)

Method	MassHealth (Massachusetts' Medicaid Program) – Contact Information
CALL	1-800-841-2900 Hours: Self-service available 24 hrs/day in English and Spanish. Other services available Mon-Fri 8:00 a.m. – 5:00 p.m. Interpreter service available. The MassHealth Enrollment Center (MEC) hours are Mon-Fri 8:45 a.m. – 5:00 p.m.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	MassHealth Central Office 100 Hancock Street, 6th Floor Quincy, MA 02171
WEBSITE	www.mass.gov/topics/masshealth

My Ombudsman works with the member, MassHealth (Medicaid), and each MassHealth (Medicaid) health plan to help resolve concerns to ensure that members receive their benefits and exercise their rights within their health plan. They can help you file a grievance or appeal with our plan.

Method	My Ombudsman – Contact Information
CALL	1-855-781-9898 Available 9:00 a.m. to 4:00 p.m., Monday through Friday. Leave a message on the My Ombudsman secure voicemail system at any time.
Videophone	1-339-224-6831
WRITE	My Ombudsman 25 Kingston Street 4th Floor Boston, MA 02111 Email: info@myombudsman.org
WEBSITE	www.myombudsman.org

The *LTC Ombudsman Program* helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

Method	A Bridge to Quality Care, the Massachusetts Long Term Care Ombudsman – Contact Information
CALL	1-800-243-4636
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Executive Office of Elder Affairs One Ashburton Place, 5th Floor Boston, MA 02109
WEBSITE	www.mass.gov/service-details/ombudsman-programs

SECTION 3 Understanding Medicare and Medicaid complaints and appeals in our plan

You have Medicare and get assistance from MassHealth (Medicaid). Information in this chapter applies to **all** of your Medicare and MassHealth (Medicaid) benefits. This is sometimes called an "integrated process" because it combines, or integrates, Medicare and MassHealth (Medicaid) processes.

Sometimes the Medicare and MassHealth (Medicaid) processes are not combined. In those situations, you use a Medicare process for a benefit covered by Medicare and a Medicaid process for a benefit covered by Medicaid. These situations are explained in **Section 6.4** of this chapter, *Step-by-step: How a Level 2 appeal* is done.

PROBLEMS ABOUT YOUR BENEFITS

SECTION 4 Coverage decisions and appeals

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The information below will help you find the right section of this chapter for problems or complaints about **benefits covered by Medicare or MassHealth (Medicaid)**.

Is your problem or concern about your benefits or coverage?

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

Yes.

Go on to the next section of this chapter, **Section 5, "A guide to the basics of coverage decisions and appeals."**

No.

Skip ahead to **Section 11** at the end of this chapter, **"How to make a complaint about quality of care, waiting times, customer service, or other concerns."**

SECTION 5 A guide to the basics of coverage decisions and appeals

Section 5.1 Asking for coverage decisions and making appeals: the big picture

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

Asking for coverage decisions prior to receiving benefits

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

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide medical care is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after a benefit is received, and you are not satisfied, you can appeal the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, which we discuss later, you can request an expedited or fast appeal of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

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

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

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

- You do not need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we do not fully agree with your Level 1 appeal.
- See **Section 6.4** of this chapter for more information about Level 2 appeals.
- For Part D drug appeals, if we say no to all or part of your appeal, you will need to ask for a Level 2 appeal. Part D appeals are discussed further in Section 7 of this chapter.

If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (Section 10 in this chapter explains the Level 3, 4, and 5 appeals processes).

Section 5.2 How to get help when you are asking for a coverage decision or making an appeal

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

- You **can call us at Member Services**.
- You **can get free help** from your Massachusetts Health Insurance Assistance Program.
- **Your doctor or other health care provider can make a request for you.** If your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Please call Member Services and ask for the *Centers for Medicare & Medicaid Services Appointment of Representative* form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.tuftsmedicarepreferred.org/forms.)
    - For medical care, your doctor or other health care provider can request a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.

- If your doctor or other health provider asks that a service or item that you are already getting be continued during your appeal, you **may** need to name your doctor or other prescriber as your representative to act on your behalf.
- For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied your doctor or prescriber can request a Level 2 appeal.

- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your representative to ask for a coverage decision or make an appeal.
  - If you want a friend, relative, or other person to be your representative, call Member Services and ask for the *Centers for Medicare & Medicaid Services Appointment of Representative* form**.** (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.tuftsmedicarepreferred.org/forms.) The form gives that person permission to act on your behalf. It must be signed by you and by the person you would like to act on your behalf. You must give us a copy of the signed form.
  - While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You may contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 5.3 Which section of this chapter gives the details for your situation?

There are four different situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 6** of this chapter, "Your medical care: How to ask for a coverage decision or make an appeal"
- **Section 7** of this chapter, "Your Part D prescription drugs: How to ask for a coverage decision or make an appeal"
- **Section 8** of this chapter, "How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon"

- **Section 9** of this chapter, "How to ask us to keep covering certain medical services if you think your coverage is ending too soon" (This section only applies to these services: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which section you should be using, call Member Services. You can also get help or information from government organizations such as your SHIP.

SECTION 6 Your medical care: How to ask for a coverage decision or make an appeal of a coverage decision

Section 6.1 This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for your care

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

This section tells what you can do if you are in any of the five following situations:

1. You are not getting certain medical care you want, and you believe that our plan covers this care. **Ask for a coverage decision. Section 6.2.**
2. Our plan will not approve the medical care your doctor or other health care provider wants to give you, and you believe that our plan covers this care. **Ask for a coverage decision. Section 6.2.**
3. You have received medical care that you believe our plan should cover, but we have said we will not pay for this care. **Make an appeal. Section 6.3.**
4. You have received and paid for medical care that you believe our plan should cover, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 6.5.**
5. You are being told that coverage for certain medical care you have been getting (that we previously approved) will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 6.3.**

Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read a Sections 8 and 9 of this chapter. Special rules apply to these types of care.

Section 6.2 Step-by-step: How to ask for a coverage decision

Legal Terms
When a coverage decision involves your medical care, it is called an **organization determination.** A fast coverage decision is called an **expedited determination.**

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

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

- You may *only ask* for coverage for medical care items and/or services (not requests for payment for items and/or services already received*)*.
- You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor tells us that your health requires a fast coverage decision, we will automatically agree to give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
  - Explains that we will use the standard deadlines
  - Explains if your doctor asks for the fast coverage decision, we will automatically give you a fast coverage decision
  - Explains that you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested.

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

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this. Chapter 2 has contact information.

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

For standard coverage decisions we use the standard deadlines.

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

- **However,** if you ask for more time, or if we need more information that may benefit you **we can take up to 14 more days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a fast complaint. We will give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. See Section 11 of this chapter for information on complaints.)

For Fast Coverage decisions we use an expedited timeframe

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

- **However,** if you ask for more time, or if we need more that may benefit you **we can take up to 14 more days**. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a fast complaint. (See Section 11 of this chapter for information on complaints.) We will call you as soon as we make the decision.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Step 4: If we say no to your request for coverage for medical care, you can appeal.

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

Section 6.3 Step-by-step: How to make a Level 1 appeal

Legal Terms
An appeal to the plan about a medical care coverage decision is called a plan **reconsideration.** A fast appeal is also called an **expedited reconsideration.**

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

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

- If you are appealing a decision we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we will give you a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 6.2 of this chapter.

Step 2: Ask our plan for an appeal or a fast appeal

- **If you are asking for a standard appeal, submit your standard appeal in writing.** You may also ask for an appeal by calling us. Chapter 2 has contact information.
- **If you are asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good cause for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a free copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal in person as well as in writing.**

If we told you we were going to stop or reduce services or items that you were already getting, you may be able to keep those services or items during your appeal.

- If we decided to change or stop coverage for a service or item that you currently get, we will send you a notice before taking the proposed action.

- If you disagree with the action, you can file a Level 1 appeal. We will continue covering the service or item if you ask for a Level 1 appeal within 10 calendar days of the postmark date on our letter or by the intended effective date of the action, whichever is later.
- If you meet this deadline, you can keep getting the service or item with no changes while your Level 1 appeal is pending. You will also keep getting all other services or items (that are not the subject of your appeal) with no changes.

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

- When we are reviewing your appeal, we take a careful look at all of the information. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if needed, possibly contacting you or your doctor.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to.
    - However, if you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service**.** If we take extra days, we will tell you in writing. We can't take extra time if your request is for a Medicare Part B prescription drug.
    - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it receives your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
    - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item

or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

- If you believe we should **not** take extra days, you can file a fast complaint. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see **Section 11** of this chapter.)
- If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal where an independent review organization will review the appeal. Section 6.4 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage within **30 calendar days**, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug, after we receive your appeal.
- **If our plan says no to part or all of your appeal, you have additional appeal rights.**
- If we say no to part or all of what you asked for, we will send you a letter.
  - If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case to the independent review organization for a Level 2 appeal.
  - If your problem is about coverage of a MassHealth (Medicaid) service or item, the letter will tell you how to file a Level 2 appeal yourself.

Section 6.4 Step-by-step: How a Level 2 appeal is done

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

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

- If your problem is about a service or item that is usually **covered by Medicare**, we will automatically send your case to Level 2 of the appeals process as soon as the Level 1 appeal is complete.
- If your problem is about a service or item that is usually **covered by MassHealth (Medicaid)**, you can file a Level 2 appeal yourself. The letter will tell you how to do this. Information is also below.
- If your problem is about a service or item that could be **covered by both Medicare and MassHealth (Medicaid)**, you will automatically get a Level 2

appeal with the independent review organization. You can also ask for a Fair Hearing with the state.

If you qualified for continuation of benefits when you filed your Level 1 appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Go to page 177 for information about continuing your benefits during Level 1 appeals.

- If your problem is about a service that is usually covered by Medicare only, your benefits for that service will not continue during the Level 2 appeals process with the independent review organization.
- If your problem is about a service that is usually covered by Medicaid, your benefits for that service will continue if you submit a Level 2 appeal within 10 calendar days after receiving the plan's decision letter.

If your problem is about a service or item Medicare usually covers:

Step 1: The independent review organization reviews your appeal.

- We will send the information about your appeal to this organization. This information is called your case file. **You have the right to ask us for a free copy of your case file**.
- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

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

- For the fast appeal the review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it receives your appeal.
- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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

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

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

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

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

- **If the independent review organization says yes to part or all of a request for a medical item or service,** we must authorize the medical care coverage **within 72 hours** or provide the service within **14 calendar days** after we receive the independent review organization's decision for **standard requests** or provide the service **within 72 hours** from the date we receive the independent review organization's decision for **expedited requests**.
- **If the independent review organization says yes to part or all of a request for a Medicare Part B prescription drug,** we must authorize or provide the Medicare Part B prescription drug **within 72 hours** after we receive the independent review organization's decision for **standard requests** or **within 24 hours** from the date we receive the independent review organization's decision for **expedited requests.**
- **If this organization says no to part or all of your appeal**, it means they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called upholding the decision or turning down your appeal.) In this case, the independent review organization will send you a letter:
  - Explaining its decision.
  - Notifying you of the right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
  - Telling you how to file a Level 3 appeal.
- If your Level 2 appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you get after your Level 2 appeal.
  - The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. **Section 10** in this chapter explains the process for Level 3, 4, and 5 appeals.

If your problem is about a service or item MassHealth (Medicaid) usually covers:

Step 1: You can ask for a Fair Hearing with the state. For SCO Medi only members, this is the only next step for the next level of appeal.

- Level 2 of the appeals process for services that are usually covered by MassHealth (Medicaid) is a Fair Hearing with the state. You must ask for a Fair Hearing in writing or over the phone **within 120 calendar days** of the date that we sent the decision letter on your Level 1 appeal. The letter you get from us will tell you where to submit your hearing request.

- If you choose to pursue an external appeal, you must submit your written hearing request to Board of Hearings within 120 calendar days from the date of mailing of the Tufts Health Plan Senior Care Options Denial notice. The Tufts Health Plan Senior Care Options Appeals and Grievances Department may assist you with this process. Hearing requests should be sent to:

  Executive Office of Health and Human Services
  Board of Hearings
  Office of Medicaid
  100 Hancock Street, 6th floor
  Quincy, MA 02171
  Or fax to 1-617-847-1204

- When you make an appeal to the Board of Hearings, we will send the information we have about your appeal to them. This information is called your "case file." **You have the right to ask us for a copy of your case file**.
- You have a right to give the Board of Hearings additional information to support your appeal.
- At the hearing, you may present yourself or your authorized representative, or be represented by a lawyer or other representative at your own expense. You may contact a local legal service or community agency to get advice or representation at no cost.

Step 2: The Fair Hearing office gives you their answer.

The Fair Hearing office will tell you their decision in writing and explain the reasons for it.

- **If the Fair Hearing office says yes to part or all of a request for a medical item or service,** we must authorize or provide the service or item within 72 hours after we receive the decision from the Fair Hearing office.

- **If the Fair Hearing office says no to part or all of your appeal**, they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called upholding the decision or turning down your appeal.)

If the decision is no for all or part of what I asked for, can I make another appeal?

If the independent review organization or Fair Hearing office decision is no for all or part of what you asked for, you have **additional appeal rights**.

The letter you get from the Fair Hearing office will describe this next appeal option.

See **Section 10** of this chapter for more information on your appeal rights after Level 2.

Section 6.5 What if you are asking us to pay you back for a bill you have received for medical care?

Note: The following section may not apply to you. Because you get assistance from MassHealth (Medicaid), you have no out-of-pocket costs for covered services.

If you have already paid for a Medicaid service or item covered by the plan, you can ask our plan to pay you back (paying you back is often called reimbursing you). It is your right to be paid back by our plan whenever you've paid for medical services or drugs that are covered by our plan. When you send us a bill you have already paid, we will look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we will pay you back for the services or drugs.

Asking for reimbursement is asking for a coverage decision from us.

If you send us the paperwork asking for reimbursement, you are asking for a coverage decision. To make this decision, we will check to see if the medical care you paid for is covered. We will also check to see if you followed all the rules for using your coverage for medical care.

If you want us to reimburse you for a **Medicare** service or item or you are asking us to pay a health care provider for a Medicaid service or item you paid for, you will ask us to make this coverage decision. We will check to see if the medical care you paid for is a covered service. We will also check to see if you followed all the rules for using your coverage for medical care.

- **If we say yes to your request:** If the medical care is covered and you followed all the rules, we will send you the payment for the cost within 60 calendar days after we receive your request.
- **If we say no to your request:** If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the medical care and the reasons why.

If you do not agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in Section 5.3. For appeals concerning reimbursement, please note:

- We must give you our answer within 30 calendar days after we receive your appeal. If you are asking us to pay you back for medical care you have already received and paid for, you are not allowed to ask for a fast appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the health care provider within 60 calendar days.

SECTION 7 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

Section 7.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (See Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs please see Chapters 5 and 6.

- **This section is about your Part D drugs only.** To keep things simple, we generally say drug in the rest of this section, instead of repeating covered outpatient prescription drug or "Part D drug" every time. We also use the term "Drug List" instead of *List of Covered Drugs or Formulary*.
- If you do not know if a drug is covered or if you meet the rules, you can ask us. Some drugs require that you get approval from us before we will cover it.
- If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

Legal Term
An initial coverage decision about your Part D drugs is called a **coverage determination.**

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs. This section tells what you can do if you are in any of the following situations:

- Asking to cover a Part D drug that is not on the plan's *List of Covered Drugs.* **Ask for an exception. Section 7.2.**
- Asking to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get). **Ask for an exception. Section 7.2.**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 7.4.**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 7.4.**

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal.

Section 7.2 What is an exception?

Legal Terms
Asking for coverage of a drug that is not on the "Drug List" is sometimes called asking for a **formulary exception.** Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **formulary exception.** Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a **tiering exception.**

If a drug is not covered in the way you would like it to be covered, you can ask us to make an exception. An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are two examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on our "Drug List".**
2. **Removing a restriction for a covered drug**. Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our "Drug List".

Section 7.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our "Drug List" includes more than one drug for treating a particular condition. These different possibilities are called alternative drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally **not** approve your request for an exception.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request, you can ask for another review by making an appeal.

Section 7.4 Step-by-step: How to ask for a coverage decision, including an exception

Legal Term
A "fast coverage decision" is called an **expedited coverage determination.**

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

Standard coverage decisions are made within **72 hours** after we receive your doctor's statement. **Fast coverage decisions** are made within **24 hours** after we receive your doctor's statement.

If your health requires it, ask us to give you a fast coverage decision. **To get a fast coverage decision, you must meet two requirements:**

- You must be asking for a *drug you have not yet received*. (You cannot ask for fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*

- **If your doctor or other prescriber tells us that your health requires a fast coverage decision, we will automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
    - Explains that we will use the standard deadlines.
    - Explains if your doctor or other prescriber asks for the fast coverage decision, we will automatically give you a fast coverage decision.
    - Tells you how you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. We will answer your complaint within 24 hours of receipt.

Step 2: Request a standard coverage decision or a fast coverage decision.

Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the *CMS Model Coverage Determination Request* form, which is available on our website. Chapter 2 has contact information.

You, your doctor, (or other prescriber) or your representative can do this. You can also have a lawyer act on your behalf. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.

- **If you are requesting an exception, provide the supporting statement,** which is the medical reasons for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

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

Deadlines for a fast coverage decision

- We must generally give you our answer **within 24 hours** after we receive your request.
    - For exceptions, we will give you our answer within 24 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
    - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.

- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a standard coverage decision about a drug you have not yet received

- We must give you our answer **within 72 hours** after we receive your request.
    - For exceptions, we will give you our answer within 72 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
    - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a standard coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.

  If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Step 4: If we say no to your coverage request, you can make an appeal.

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

Section 7.5 Step-by-step: How to make a Level 1 appeal

Legal Term
An appeal to the plan about a Part D drug coverage decision is called a plan **redetermination.** A fast appeal is also called an **expedited redetermination.**

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

A standard appeal is usually made within 7 days. A fast appeal is generally made within 72 hours. If your health requires it, ask for a fast appeal

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 6.4 of this chapter.

Step 2: You, your representative, doctor or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a fast appeal.

- **For standard appeals, submit a written request,** or call us. Chapter 2 has contact information.

  If you have someone appealing our decision for you other than your doctor, your appeal must include an Appointment of Representative form authorizing this person to represent you. If your doctor or other prescriber is asking that a service or item you are already getting be continued during your appeal, you may need to name your doctor or other prescriber as your representative to act on your behalf. (To get the form, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the *CMS Medicare Appointment of Representative* form. It is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf) While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.
- **For fast appeals either submit your appeal in writing or call us at (**1-855-670-5934). Chapter 2 has contact information.
- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.

Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request.

- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal.

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

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to.
    - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. **Section 7.6** explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal for a drug you have not yet received

- For standard appeals, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.
    - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. **Section 7.6** explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you requested,** we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
    - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 30 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make another appeal.

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

Section 7.6 Step-by-step: How to make a Level 2 appeal

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

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

Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the review organization. If, however, we did not complete our review within the applicable timeframe, or make an unfavorable decision regarding at-risk determination under our drug management program, we will automatically forward your claim to the IRE.

- We will send the information about your appeal to this organization. This information is called your case file. **You have the right to ask us for a copy of your case file**.
- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal.

Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

Deadlines for fast appeal

- If your health requires it, ask the independent review organization for a fast appeal.
- If the organization agrees to give you a fast appeal, the organization must give you an answer to your Level 2 appeal **within 72 hours** after it receives your appeal request.

Deadlines for standard appeal

- For standard appeals, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it receives your appeal if it is for a drug you have not yet received. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it receives your request.

Step 3: The independent review organization gives you their answer.

For fast appeals:

- **If the independent review organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

For standard appeals:

- **If the independent review organization says yes to part or all of your request for coverage,** we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
- **If the independent review organization says yes to part or all of your request to pay you back** for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to part or all of your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called **upholding the decision** or **turning down your appeal**.) In this case, the independent review organization will send you a letter:

- Explaining its decision.
- Notifying you of the right to a Level 3 appeal if the dollar value of the drug coverage you are requesting meets a certain minimum. If the dollar value of the drug coverage requesting is too low, you cannot make another appeal and the decision at Level 2 is final.
- Telling you the dollar value that must be in dispute to continue with the appeals process.

Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go on to Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. **Section 10** of this chapter talks more about the process for Level 3, 4, and 5 appeals.

SECTION 8 How to ask us to cover a longer inpatient hospital stay if you think you are being discharged too soon

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

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will help arrange for care you may need after you leave.

- The day you leave the hospital is called your **discharge date**.
- When your discharge date is decided, your doctor or the hospital staff will tell you.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered.

Section 8.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

Within two days of being admitted to the hospital, you will be given a written notice called *An Important Message from Medicare about Your Rights.* Everyone with Medicare gets a copy of this notice.

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

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you:
   - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
   - Your right to be involved in any decisions about your hospital stay.
   - Where to report any concerns you have about the quality of your hospital care.
   - Your right to **request an immediate review** of the decision to discharge you if you think you are being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time.

2. **You will be asked to sign the written notice to show that you received it and understand your rights.**
   - You or someone who is acting on your behalf will be asked to sign the notice.
   - Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date. Signing the notice **does *not* mean** you are agreeing on a discharge date.

3. **Keep your copy** of the notice handy so you will have the information about making an appeal (or reporting a concern about quality of care) if you need it.
   - If you sign the notice more than two days before your discharge date, you will get another copy before you are scheduled to be discharged.
   - To look at a copy of this notice in advance, you can call Member Services or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeappealNotices.

Section 8.2 Step-by-step: How to make a Level 1 appeal to change your hospital discharge date

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it**. If you have questions or need help at any time, call Member Services. Or call the Massachusetts' Health Insurance Assistance Program (SHIP), a government organization that provides personalized assistance. In Massachusetts, the SHIP is called SHINE (Serving the Health Insurance Needs of Everyone). You can find the address and phone number for SHINE in Chapter 2.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

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

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

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for Massachusetts in Chapter 2.

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge.**
    - **If you meet this deadline**, you may stay in the hospital *after* your discharge date **without paying for it** while you wait to get the decision from the Quality Improvement Organization.
    - **If you do *not* meet this deadline**, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.

- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see Section 8.4 of this chapter.

Once you request an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted we will give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

You can get a sample of the **Detailed Notice of Discharge** by calling Member Services or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeappealNotices.

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

- Health professionals at the Quality Improvement Organization ("the reviewers") will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers told us of your appeal, you will get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the review organization says yes, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services.

What happens if the answer is no?

- If the review organization says no, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital**

services will end at noon on the day **after** the Quality Improvement Organization gives you its answer to your appeal.

- If the review organization says no to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization has said *no* to your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to **Level 2** of the appeals process.

Section 8.3 Step-by-step: How to make a Level 2 appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at their decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

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

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said no to your Level 1 appeal. You can ask for this review only if you stay in the hospital after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary**.

- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

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

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. **Section 10** of this chapter talks more about Levels 3, 4, and 5 of the appeals process.

Section 8.4 What if you miss the deadline for making your Level 1 appeal?

Legal Term
A fast review (or fast appeal) is also called an **expedited appeal**.

You can appeal to us instead

As explained above, you must act quickly to start your Level 1 appeal of your hospital discharge. If you miss the deadline for contacting the Quality Improvement Organization, there is another way to make your appeal.

If you use this other way of making your appeal, **the first two levels of appeal are different.**

Step-by-Step: How to make a Level 1 Alternate appeal

Step 1: Contact us and ask for a fast review.

- **Ask for a fast review.** This means you are asking us to give you an answer using the fast deadlines rather than the standard deadlines. Chapter 2 has contact information.

Step 2: We do a fast review of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We see if the decision about when you should leave the hospital was fair and followed all the rules.

Step 3: We give you our decision within 72 hours after you ask for a fast review.

- **If we say yes to your appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date. We will keep providing your covered inpatient hospital services for as long as they are medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs, and there may be coverage limitations that apply.)
- **If we say no to your appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
    - If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

Step 4: If we say *no* to your appeal, your case will automatically be sent on to the next level of the appeals process.

Step-by-Step: Level 2 *Alternate* appeal Process

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

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

Step 1: We will automatically forward your case to the independent review organization.

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 11 of this chapter tells how to make a complaint.)

Step 2: The independent review organization does a fast review of your appeal. The reviewers give you an answer within 72 hours.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says yes to your appeal,** then we must pay you back for our share of the costs of hospital care you received since the date of your planned discharge. We must also continue the plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says no to your appeal,** it means they agree that your planned hospital discharge date was medically appropriate.
    - The written notice you get from the independent review organization will tell you how to start a Level 3 appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 3: If the independent review organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 appeal, you decide whether to accept their decision or go on to Level 3 appeal.
- Section 10 of this chapter talks more about the process for Level 3, 4, and 5 appeals.

SECTION 9 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 9.1 This section is only about three services: Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

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

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, **we will stop paying** for your care.

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

Section 9.2 We will tell you in advance when your coverage will be ending

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

1. **You receive a notice in writing** at least two days before our plan is going to stop covering your care. The notice tells you:
   - The date when we will stop covering the care for you.
   - How to request a fast track appeal to request us to keep covering your care for a longer period of time.
2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you received it.** Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with the plan's decision to stop care.

Section 9.3 Step-by-step: How to make a Level 1 appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it**. If you have questions or need help at any time, call Member Services. Or call the Massachusetts' Health Insurance Assistance Program (SHIP), a government organization that provides personalized assistance. In Massachusetts, the SHIP is called SHINE (Serving the Health Insurance Needs of Everyone). You can find the address and phone number for SHINE in Chapter 2.

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

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

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

How can you contact this organization?

- The written notice you received (*Notice of Medicare Non-Coverage*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for Massachusetts in Chapter 2.

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the Notice of Medicare Non-Coverage.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see Section 9.5 of this chapter.

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

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

What happens during this review?

- Health professionals at the Quality Improvement Organization ("the reviewers") will ask you, or your representative, why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers told us of your appeal, you will get the **Detailed Explanation of Non-Coverage** from us that explains in detail our reasons for ending our coverage for your services.

Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.

What happens if the reviewers say yes?

- If the reviewers say yes to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say no, then **your coverage will end on the date we have told you.**
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services **after** this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If reviewers say no to your Level 1 appeal *and* you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 appeal.

Section 9.4 Step-by-step: How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

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

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said *no* to your Level 1 appeal. You could ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes?

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

What happens if the review organization says no?

- It means they agree with the decision made to your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 10 of this chapter tells more about the process for Level 3, 4, and 5 appeals.

Section 9.5 What if you miss the deadline for making your Level 1 appeal?

You can appeal to us instead

As explained above, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, **the first two levels of appeal are different**.

Step-by-Step: How to make a Level 1 Alternate appeal

Legal Term
A fast review (or fast appeal) is also called an **expedited appeal**.

Step 1: Contact us and ask for a fast review.

- **Ask for a fast review**. This means you are asking us to give you an answer using the fast deadlines rather than the standard deadlines. Chapter 2 has contact information.

Step 2: We do a fast review of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan's coverage for services you were receiving.

Step 3: We give you our decision within 72 hours after you ask for a fast review.

- **If we say yes to your appeal,** it means we have agreed with you that you need services longer, and we will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs, and there may be coverage limitations that apply.)
- **If we say no to your appeal,** then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end, then **you will have to pay the full cost** of this care.

Step 4: If we say no to your fast appeal, your case will automatically go on to the next level of the appeals process.

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

Step-by-Step: Level 2 Alternate Appeal Process

During the Level 2 appeal, the **independent review organization** reviews the decision we made to your fast appeal. This organization decides whether the decision should be changed. **The**

independent review organization is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the independent review organization. Medicare oversees its work.

Step 1: We automatically forward your case to the independent review organization.

- We are required to send the information for your Level 2 appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 11 of this chapter tells how to make a complaint.)

Step 2: The independent review organization does a fast review of your appeal. The reviewers give you an answer within 72 hours.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.
- **If this organization says yes to your appeal,** then we must pay you back for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover services.
- **If this organization says no to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
    - The notice you get from the independent review organization will tell you in writing what you can do if you wish to go on to a Level 3 appeal.

Step 3: If the independent review organization says no to your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- A Level 3 appeal is reviewed by an Administrative Law Judge or attorney adjudicator. Section 10 of this chapter talks more about the process for Level 3, 4, and 5 appeals.

SECTION 10 Taking your appeal to Level 3 and beyond

Section 10.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

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

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

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

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process may or may not be over**. Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that is favorable to you. If we decide to appeal it will go to a Level 4 appeal.
    - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator's decision.
    - If we decide to appeal the decision, we will send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over**.
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

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

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may* or *may not* be over.** Unlike a

decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We will decide whether to appeal this decision to Level 5.

- If we decide **not** to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after receiving the Council's decision.
- If we decide to appeal the decision, we will let you know in writing.

- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 appeal and how to continue with a Level 5 appeal.

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

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

Section 10.2 Additional MassHealth (Medicaid) appeals

You also have other appeal rights if your appeal is about services or items that MassHealth Standard (Medicaid) usually covers. The letter you get from the Fair Hearing office will tell you what to do if you wish to continue the appeals process. Please refer to Section 6.4 (Page 182) for additional detail.

Section 10.3 Appeal Levels 3, 4 and 5 for Part D Drug Requests

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

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

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

- **If the answer is yes, the appeals process is over**. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

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

- **If the answer is yes, the appeals process is over**. We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process may or may not be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice will tell you whether the rules allow you to go on to a Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your appeal.

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

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

SECTION 11 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 11.1 What kinds of problems are handled by the complaint process?

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

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Member Services? • Do you feel you are being encouraged to leave the plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Services or other staff at the plan? o Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?

Complaint	Example
Timeliness (These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)	If you have asked for a coverage decision or made an appeal and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a fast coverage decision or a fast appeal, and we have said no; you can make a complaint. • You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we are not meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 11.2 How to make a complaint

Legal Terms

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

Section 11.3 Step-by-step: Making a complaint

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

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- You may file a grievance at any time. You can do so by calling Member Services at 1-855-670-5934 (TTY 711). Representatives are available 8:00 a.m. to 8:00 p.m., 7 days a

week from October 1 to March 31 and Monday – Friday from April 1 to September 30. After hours and on holidays, please leave a message and a representative will return your call on the next business day. You can also file a grievance in writing by sending it by mail to: Tufts Health Plan Senior Care Options, Attn: Appeals & Grievances Department, P.O. Box 474, Canton, MA 0202-1166. You can also send it in writing via fax at: 1-617-972-9516. You may add more information to support your complaint in person as well as in writing.

We will acknowledge your grievance once we receive it.

- You also have the right to file an expedited Grievance which could include a complaint that Tufts Health Plan Senior Care Options refused to expedite an organization determination, coverage determination, reconsideration, or redetermination, or invoked an extension to an organization determination or reconsideration time frame(s). The time frame for Tufts Health Plan Senior Care Options to respond is within 24 hours of your complaint.
- **Whether you call or write, you should contact Member Services right away.** You can make the complaint at any time after you had the problem you want to complain about.

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If you are making a complaint because we denied your request for a fast coverage decision or a fast appeal, we will automatically give you a fast complaint.** If you have a fast complaint, it means we will give you **an answer within 24 hours**.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will include our reasons in our response to you.

Section 11.4 You can also make complaints about quality of care to the Quality Improvement Organization

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

- **You can make your complaint directly to the Quality Improvement Organization.** The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

Or

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

Section 11.5 You can also tell Medicare and MassHealth (Medicaid) about your complaint

You can submit a complaint about Tufts Health Plan Senior Care Options directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

You can submit a complaint about Tufts Health Plan Senior Care Options anytime directly to MassHealth (Medicaid). You can do this by calling the MassHealth (Medicaid) Member Services Center at 1-800-841-2900 (TTY 711) Monday – Friday 8:00 a.m. to 5:00 p.m.

Section 11.6 Complaints about behavioral health parity

Federal and state laws require that all managed care organizations, including Tufts Health Plan Senior Care Options, provide behavioral health services to MassHealth Standard (Medicaid) members in the same way they provide physical health services. This is what is referred to as "parity". In general, this means that:

1. Tufts Health Plan Senior Care Options must provide the same level of benefits for any behavioral health and substance use disorder problems you may have as for other physical problems you may have;
2. Tufts Health Plan Senior Care Options must have similar prior authorization requirements and treatment limitations for behavioral health and substance use disorder services as it does for physical health services;
3. Tufts Health Plan Senior Care Options must provide you or your provider with the medical necessity criteria used by Tufts Health Plan Senior Care Options for prior authorization upon your or your provider's request; and
4. Tufts Health Plan Senior Care Options must also provide you within a reasonable time frame the reason for any denial of authorization for behavioral or substance use disorder services.

If you think that Tufts Health Plan Senior Care Options is not providing parity as explained above, you have the right to file a Grievance with Tufts Health Plan Senior Care Options. For more information about Grievances and how to file them, please review the section on how to make a complaint earlier in this chapter.

SECTION 12 Reporting Fraud, Waste, or Abuse

Section 12.1 What are Fraud, Waste, and Abuse?

Fraud, Waste and Abuse are the terms used to describe instances where the conduct of a provider or member causes Tufts Health Plan Senior Care Options or the federal or state government to make an unwarranted or unnecessary payment.

- **Fraud:** Describes any type of intentional misrepresentation made with the purpose of causing an unwarranted payment.
- **Waste:** Describes instances where the actions of a provider or member cause unnecessary use of healthcare resources. Waste is not on purpose.
- **Abuse:** Describes other actions that result in excess cost or payments for services that are not medically necessary or not the accepted standard of care.

Section 12.2 What is the Fraud, Waste, and Abuse Hotline

Has anyone ever offered you free medical services or supplies in exchange for your Medicare number? Have you ever been charged more than once for the same service or charged for services, equipment or supplies you did not receive? Hopefully not, but if something like this ever happens to you, Tufts Health Plan has a Hotline for members to report concerns about possible health care fraud. The Hotline was established to help Tufts Health Plan's members who have questions, concerns and/or complaints related to possible wasteful, fraudulent, or abusive activity.

You can call the Tufts Health Plan Fraud Hotline to report your concerns 24 hours a day, 7 days a week at 1-877-824-7123 (TTY: 711). Any call you make to the Hotline will not be recorded. The information you provide will be forwarded within one business day to the Tufts Health Plan Corporate Compliance department to address your concerns.

You may choose to identify yourself or to remain anonymous. Our policy is to preserve the anonymity of Hotline callers, subject to limits imposed by the law. In some cases we are legally required to report certain types of potential crimes and infractions to external agencies. Please understand that reporting any concerns or complaints will not affect your right to health care coverage and services in any way.

Health care fraud and abuse affect everyone by contributing to the increase of health care costs. You can play an active role in keeping your health care costs down by reporting any potential fraudulent practices to the Tufts Health Plan Fraud Hotline.

CHAPTER 9:
Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

Ending your membership in Tufts Health Plan Senior Care Options may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave. Sections 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, our plan must continue to provide your medical care and prescription drugs and you will continue to pay your cost share until your membership ends.

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

Section 2.1 You may be able to end your membership because you have Medicare and MassHealth (Medicaid)

Most people with Medicare can end their membership only during certain times of the year. Because you have MassHealth (Medicaid), you may be able to end your membership in our plan or switch to a different plan one time during each of the following Special Enrollment Periods:

- January to March
- April to June
- July to September

If you joined our plan during one of these periods, you'll have to wait for the next period to end your membership or switch to a different plan. You can't use this Special Enrollment Period to end your membership in our plan between October and December. However, all people with Medicare can make changes from October 15 – December 7 during the Annual Enrollment Period. Section 2.2 tells you more about the Annual Enrollment Period.

- Choose any of the following types of Medicare plans:
    - Another Medicare health plan, with or without prescription drug coverage
    - Original Medicare *with* a separate Medicare prescription drug plan
    - Original Medicare without a separate Medicare prescription drug plan
        - If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

    Note: If you disenroll from Medicare prescription drug coverage and go without "creditable" prescription drug coverage for a continuous period of 63 days or more,

you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

Contact MassOptions to learn about your MassHealth (Medicaid) plan options (telephone numbers are in Chapter 2, Section 6 of this document).

- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plans. Your enrollment in your new plan will also begin on this day.

Section 2.2 You can end your membership during the Annual Enrollment Period

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

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

If you receive "Extra Help" from Medicare to pay for your prescription drugs: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

Section 2.3 You can end your membership during the Medicare Advantage Open Enrollment Period

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

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

Section 2.4 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, you may be eligible to end your membership at other times of the year. This is known as a **Special Enrollment Period**.

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

- Usually, when you have moved.
- If you have MassHealth (Medicaid).
- If you are eligible for "Extra Help" with paying for your Medicare prescriptions.
- If we violate our contract with you.
- If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital.
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE).

Note: If you're in a drug management program, you may not be able to change plans. Chapter 5, Section 10 tells you more about drug management programs.

- **The enrollment time periods vary** depending on your situation.
- **To find out if you are eligible for a Special Enrollment Period**, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:
- Another Medicare health plan with or without prescription drug coverage.
- Original Medicare *with* a separate Medicare prescription drug plan

OR

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

  Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

If you receive "Extra Help" from Medicare to pay for your prescription drugs: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

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

Note: Sections 2.1 and 2.2 tell you more about the special enrollment period for people with MassHealth Standard (Medicaid) and Extra Help.

Section 2.5 Where can you get more information about when you can end your membership?

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

- **Call Member Services**
- Find the information in the ***Medicare & You 2024*** handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

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

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

If you would like to switch from our plan to:	This is what you should do:
Another Medicare health plan	• Enroll in the new Medicare health plan. Your new coverage will begin on the first day of the following month. • You will automatically be disenrolled from Tufts Health Plan Senior Care Options when your new plan's coverage begins.

If you would like to switch from our plan to:	This is what you should do:
Original Medicare *with* a separate Medicare prescription drug plan	• Enroll in the new Medicare prescription drug plan. Your new coverage will begin on the first day of the following month. • You will automatically be disenrolled from Tufts Health Plan Senior Care Options when your new plan's coverage begins.
Original Medicare *without* a separate Medicare prescription drug plan o If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment. o If you disenroll from Medicare prescription drug coverage and go 63 days or more in a row without creditable prescription drug coverage, you may have to pay a late enrollment penalty if you join a Medicare drug plan later.	• **Send us a written request to disenroll** Contact Member Services if you need more information on how to do this. • You can also contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from Tufts Health Plan Senior Care Options when your coverage in Original Medicare begins.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

For questions about your MassHealth Standard (Medicaid) benefits, contact MassHealth (Medicaid) at 1-800-841-2900 (TTY 711), Monday – Friday, from 8:00 a.m. – 5:00 p.m. The MassHealth Enrollment Center (MEC) hours are Monday – Friday, from 8:00 a.m. – 5:00 p.m. Ask how joining another plan or returning to Original Medicare affects how you get your MassHealth Standard (Medicaid) coverage.

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

Until your membership Tufts Health Plan Senior Care Options ends, and your new Medicare and MassHealth (Medicaid) coverage begins, you must continue to get your medical items, services and prescription drugs through our plan.

- **Continue to use our network providers to receive medical care.**
- **Continue to use our network pharmacies to get your prescriptions filled.**
- **If you are hospitalized on the day that your membership ends, your hospital stay will be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 Tufts Health Plan Senior Care Options must end your membership in the plan in certain situations

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

Tufts Health Plan Senior Care Options must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B
- If you are no longer eligible for MassHealth Standard (Medicaid). As stated in Chapter 1, Section 2.1, our plan is for people who are eligible for both Medicare and MassHealth Standard (Medicaid). If you lose eligibility for MassHealth Standard (Medicaid) benefits, Tufts Health Plan Senior Care Options will continue to provide care as long as you can reasonably be expected to regain your MassHealth Standard (Medicaid) coverage within one month. We will continue your membership for the remainder of the month in which we receive notification from MassHealth (Medicaid) about your loss of eligibility, along with one additional calendar month. If you regain your MassHealth Standard (Medicaid) coverage during this period, we will not end your membership.
- If you move out of our service area
- If you are away from our service area for more than six months
    - If you move or take a long trip, call Member Services to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison)
- If you are no longer a United States citizen or lawfully present in the United States
- If you lie or withhold information about other insurance you have that provides prescription drug coverage. **Note**: Members who have other comprehensive health insurance other than Medicare are not eligible for SCO, regardless of whether they lie about it or not.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)

- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan.

Where can you get more information?

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

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

Tufts Health Plan Senior Care Options is not allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week (TTY 1-877-486-2048).

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

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

CHAPTER 10:
Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws are not included or explained in this document.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, behavioral or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at https://www.hhs.gov/ocr/index.html.

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

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Tufts Health Plan Senior Care Options, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

SECTION 4 Notice about the relationship between Tufts Health Plan Senior Care Options and providers

Tufts Health Plan Senior Care Options provides coverage for health care services. Tufts Health Plan Senior Care Options does not provide health care services. Tufts Health Plan Senior Care Options has contractual agreements with providers practicing in facilities and private offices throughout the service area. These providers are independent. They are not Tufts Health Plan Senior Care Options employees, or representatives. Providers are not authorized to change this *Evidence of Coverage* or assume or create any obligation for Tufts Health Plan Senior Care Options that is inconsistent with this *Evidence of Coverage*.

SECTION 5 Notice about Section 1557 of the Affordable Care Act

Tufts Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, 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
  - Information written in other languages

If you need these services, contact Tufts Health Plan at 1-855-670-5934 (TTY 711).

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

Tufts Health Plan, Attention:

Civil Rights Coordinator, Legal Dept.
1 Wellness Way
Canton, MA 02021

Phone: 1-888-880-8699 ext. 48000
TTY number: 1-800-439-2370 or 711
Español: 1-866-930-9252
Fax: 1-617-972-9048
Email: OCRCoordinator@point32health.org

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

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building,
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TDD).

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

CHAPTER 11:
Definitions of important words

Note: References to cost-sharing in the definitions below do not apply to Tufts Health Plan Senior Care Options members. Because you get assistance from MassHealth (Medicaid), you have no out-of-pocket costs for covered services.

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Aging Services Access Point (ASAP) – An entity that contracts with the Massachusetts Executive Office of Elder Affairs to manage the Home Care Program, providing seniors access to long term services and supports.

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

Benefit Period –The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you have not received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf have spent $8,000 for Part D covered drugs during the covered year. Because you get assistance from MassHealth (Medicaid), you have no cost share for covered services.

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

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

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

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services or drugs are received. Cost sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed "copayment" amount that a plan requires when a specific service or drug is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a service or drug that a plan requires when a specific service or drug is received. Because you get assistance from MassHealth (Medicaid), you have no cost share for covered services.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one cost-sharing tier. Tufts Health Plan Senior Care Options Members are not responsible for cost-sharing for covered drugs.

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called coverage decisions in this document.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

Covered Services – The term we use to mean all of the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care, provided by people who do not have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care. Custodial Care is covered by MassHealth Standard (Medicaid).

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

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist's time to prepare and package the prescription.

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

Dual Eligible Individual – A person who qualifies for Medicare and MassHealth (Medicaid) coverage.

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

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care – Covered services that are: (1) provided by a provider qualified to furnish emergency services; and (2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage decision that, if approved, allows you to get a drug that is not on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also request an exception if our plan requires you to try another drug before receiving the drug you are requesting, or if our plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Extra Help – A Medicare or a State program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a "generic" drug works the same as a brand name drug and usually costs less.

Geriatric Support Services Coordinator (GSSC) – An employee of the Aging Services Access Point (ASAP) who has been certified as meeting qualifications to participate as part of a Primary Care Team (PCT).

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

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an "outpatient."

Income Related Monthly Adjustment Amount (IRMAA) –If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Institutional Equivalent Special Needs Plan (SNP) – A plan that enrolls eligible individuals living in the community but requiring an institutional level of care based on the State assessment. The assessment must be performed using the same respective State level of care assessment tool and administered by an entity other than the organization offering the plan. This type of Special Needs Plan may restrict enrollment to individuals that reside in a contracted assisted living facility (ALF) if necessary to ensure uniform delivery of specialized care.

Institutional Special Needs Plan (SNP) – A plan that enrolls eligible individuals who continuously reside or are expected to continuously reside for 90 days or longer in a long-term care (LTC) facility. These facilities may include a skilled nursing facility (SNF), nursing facility (NF), (SNF/NF); an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), an inpatient psychiatric facility, and/or facilities approved by CMS that furnishes similar long-term, healthcare services that are covered under Medicare Part A, Medicare Part B, or Medicaid; and whose residents have similar needs and healthcare status to the other named facility types. An institutional Special Needs Plan must have a contractual arrangement with (or own and operate) the specific LTC facility(ies).

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

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

List of Covered Drugs (Formulary or "Drug List") – A list of prescription drugs covered by the plan.

Low Income Subsidy (LIS) – See "Extra Help."

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

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for covered Part A and Part B services. You must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by MassHealth (Medicaid) or another third party). Amounts you pay for your plan premiums, Medicare Part A and Part B premiums, and prescription drugs do not count toward the maximum out-of-pocket amount. (Note: Because our members also get assistance from MassHealth (Medicaid), very few members ever reach this out-of-pocket maximum.) See Chapter 4, Section 1.2 for information about your maximum out-of-pocket amount. Note: Because you get assistance from MassHealth (Medicaid), you have no cost share for covered services.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

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

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an i) HMO, ii) PPO, a iii) Private Fee-for-Service (PFFS) plan, or a iv) Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP) In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand name drugs to Part D members who have reached the Coverage Gap Stage and who are not already receiving "Extra Help." Discounts are based on agreements between the Federal government and certain drug manufacturers.

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

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Medigap (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or Plan Member) – A person with MassHealth Standard (Medicaid) and Medicare who is eligible to get covered services, who has enrolled in our plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

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

Network Pharmacy –A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider – Provider is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. **Network providers** have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called "plan providers."

Original Medicare (Traditional Medicare or Fee-for-service Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that does not have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that does not have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan.

Out-of-Pocket Costs – See the definition for cost sharing above. A member's cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member's out-of-pocket cost requirement. SCO members do not have a cost to covered services.

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

Part C – see Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded from Part D coverage by Congress. Certain categories of Part D drugs must be covered by every plan.

Part D Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you are first eligible to join a Part D plan. If you lose Extra Help, you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable prescription drug coverage.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both network (preferred) and out-of-network (non-preferred) providers. SCO members do not have a cost to covered services.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage. SCO members do not have a cost to covered services.

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

Primary Care Team (PCT) – The team, including the member's Care Manager, Primary Care Physician, Specialists, and other support staff that work together to coordinate and provide the member's medical care, behavioral health care, and community support services.

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

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

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Real Time Benefit Tool – A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit

information. This includes cost sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan must disenroll you if you permanently move out of the plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and MassHealth (Medicaid), who reside in a nursing home, or who have certain chronic medical conditions.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

TUFTS Health Plan

a Point32Health company

Multi-language Interpreter Services

English: We have free interpreter services available for people who require translation services to answer any questions you may have about our health or drug plan. We can also give you information in English, braille, large print, or other alternate format. Just call us at 1-855-670-5934. Someone who speaks English can help you. This is a free service.

Spanish: Contamos con servicios gratuitos de intérpretes disponibles para personas que requieren servicios de traducción para responder cualquier pregunta que usted pueda tener sobre nuestro plan de salud o medicamentos. También podemos brindarle información en español, braille, letra grande u otro formato alternativo. Simplemente llámenos al 1-855-670-5934. Una persona que habla español le puede ayudar. Este es un servicio gratuito.

Chinese Simplified: 我们为需要翻译服务的人提供免费口译服务，回答您对我们的健康或药物计划的任何问题。我们还可以以简体中文、盲文、大字体或其他替代格式为您提供信息。请致电 1-855-670-5934 联系我们。会说普通话的人会帮助您。本项服务免费。

Chinese Traditional: 我們為有翻譯服務需求者提供免費口譯服務，以針對我們的健康或藥物計劃，為您回答任何您可能提出的問題。我們也以繁體中文、點字、大字體或其他替代格式為您提供資訊。請撥打電話：1-855-670-5934。會說中文的人可以協助您。此為免費服務。

Tagalog: Mayroon kaming mga libreng serbisyo ng interpreter na magagamit ng mga taong nangangailangan ng mga serbisyo ng pagsasalin upang masagot ang anumang maaaring tanong mo tungkol sa aming plano sa kalusugan o gamot. Maaari din kaming magbigay sa iyo ng impormasyon na nasa Tagalog, braille, malalaking titik, o iba pang alternatibong format. Tumawag lang sa amin sa 1-855-670-5934. Matutulungan ka ng isang taong nagsasalita ng Tagalog. Isa itong libreng serbisyo.

French: Nous mettons des services d'interprétariat gratuits à la disposition de tous ceux qui ont besoin de services de traduction pour répondre aux questions que vous pourriez poser sur notre régime d'assurance-maladie ou médicaments. Nous pouvons vous fournir des informations en français, braille, lettres majuscules, ou tout autre format. Veuillez nous appeler au 1-855-670-5934. Une personne qui parle français pourra vous assister. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí cho người cần phiên dịch để trả lời bất kỳ câu hỏi nào mà quý vị có thể có về chương trình bảo hiểm y tế hay chương trình thuốc của chúng tôi. Chúng tôi cũng có thể cung cấp thông tin cho quý vị bằng Tiếng Việt, chữ nổi braille, bản in chữ lớn, hay định dạng thay thế khác. Quý vị chỉ cần gọi chúng tôi theo số 1-855-670-5934. Một người nói Tiếng Việt có thể giúp quý vị. Đây là dịch vụ miễn phí.

German: Wir stellen Dolmetscherdienste kostenlos all jenen zur Verfügung, die zwecks Beantwortung ihrer Fragen zu den für sie geltenden Kostenübernahme- und Zuzahlungsregeln Übersetzungsdienste benötigen. Zudem informieren wir Sie bei Bedarf in Deutsch, Brailleschrift, Großdruck oder anderen Formaten. Rufen Sie uns einfach an: 1-855-670-5934. Hier erhalten Sie Hilfe von jemand, der Deutsch spricht. Dieser Service ist kostenlos.

Korean: 번역 서비스가 필요하신 분들에게 건강 플랜 또는 약품 플랜에 대한 문의에 답변을 드리기 위해 무료 통역 서비스를 제공합니다. 또한 한국어, 점자, 큰 활자 또는 기타 대체 형식으로 정보를 제공할 수 있습니다. 1-855-670-5934번으로 전화해 주십시오. 한국어를 구사하는 사람이 도와드릴 수 있습니다. 통역은 무료 서비스입니다.

Russian: Мы предоставляем бесплатную услугу устного перевода для людей, которым он необходим, чтобы ответить на вопросы о здоровье или плане получения рецептурных препаратов. Мы также можем предоставить вам информацию на русском языке, с использованием шрифта Брайля, крупным шрифтом или в другом альтернативном формате. Просто позвоните по номеру 1-855-670-5934. Вам поможет сотрудник, владеющий русским языком. Это — бесплатная услуга.

Arabic: لدينا خدمات ترجمة فورية مجانية متاحة للأشخاص الذين يحتاجون إلى خدمات الترجمة للإجابة عن أي أسئلة قد تكون لديك حول خطتنا الصحية أو الدوائية. يمكننا أيضًا تزويدك بالمعلومات باللغة العربية أو بطريقة برايل أو بحروف كبيرة أو بأي تنسيق بديل آخر. كل ما عليك هو الاتصال بنا على الرقم 1-855-670-5934. يمكن أن يقوم شخص يتحدث باللغة العربية بمساعدتك. هذه الخدمة مجانية.

Hindi: हमारे पास उन लोगों केलिए मुफ्त दुभाषिया सेवाएंउपलब्ध हैं जिन्हें हमारी स्वास्थ्य या दवा योजना केबारेमें उनकेकिसी भी प्रश्न का उत्तर देनेकेलिए अनुवाद सेवाओ की आवश्यकता है। हम आपको हिंदी, ब्रेल, बड़े प्रिंट या अन्य वैकल्पिक प्रारूप में भी जानकारी दे सकते हैं। बस हमें 1-855-670-5934 पर कॉल करें हिन्दी बोलने वाला कोई व्यक्ति आपकी मदद कर सकता है। यह एक निःशुल्क सेवा है।

Italian: Se occorre una traduzione, i nostri servizi di interpretariato sono disponibili gratuitamente per offrire chiarimenti e risposte in merito al nostro piano sanitario o per i medicinali. Possiamo offrire informazioni anche in italiano, braille, caratteri grandi o altri formati. Non esiti a chiamarci al recapito 1-855-670-5934. Una persona che parla italiano sarà pronta a offrire assistenza. Questo servizio è gratuito.

Portuguese: Temos serviços de interpretação gratuitos para quem necessite de serviços de tradução para responder a qualquer questão que possamos ter sobre o seu plano de saúde ou medicamentação. Também podemos dar todas as informações em Português, braille, letra de grande dimensão ou formato alternativo. Basta ligar para o 1-855-670-5934. Alguém fala Português e poderá ajudar. É um serviço gratuito.

French Creole: Nou gen sèvis entèprèt gratis ki disponib pou moun ki bezwen sèvis tradiksyon pou reponn nenpòt kesyon ou ka genyen sou plan sante oswa anrapò ak plan medikaman nou an. Nou kapab ba w enfòmasyon tou nan lang Kreyòl ayisyen, bray, gwo lèt, oswa lòt fòma. Jis rele nou nan 1-855-670-5934. Yon moun ki pale lang Kreyòl ayisyen ka ede w. Sa a se yon sèvis gratis.

Polish: Osobom potrzebującym tłumaczenia oferujemy bezpłatne usługi tłumacza, który odpowie na wszelkie pytania związane z naszym planem zdrowotnym lub dotyczącym leków. Możemy również udzielić informacji w języku polskim, alfabecie Braille'a, dużym druku lub innym alternatywnym formacie. Wystarczy zadzwonić pod numer 1-855-670-5934. Ktoś mówiący w języku polskim może Ci pomóc. Jest to usługa bezpłatna.

Japanese: 私たちの医療や医薬品の計画に関する、どのような質問にもお答えするため、翻訳サービスが必要な方のための無料通訳サービスを提供しています。情報は、日本語、点字、大活字、その他の代替形式でも提供可能です。1-855-670-5934 にお電話ください。日本語対応でお手伝いいたします。これは無料のサービスです。

Khmer: យើងមានសេវាកម្មអ្នកបកប្រែផ្តាល់មាត់ដោយឥតគិតថ្លៃសម្រាប់អ្នក ដែលត្រូវការសេវាកម្មបកប្រែ ដើម្បីឆ្លើយសំណួ រណាមួយដែលអ្នកអាចមាន ទាក់ទងនឹងគម្រោងសុខភាព ឬឱសថរបស់យើង។ យើងក៏អាចផ្តល់ជូនអ្នកនូវព័ត៌មានជាភាសា ខ្មែរ អក្សរសម្រាប់ជនពិការផ្នែក អក្សរពុម្ពធំ ឬជាទម្រង់ដទៃផ្សេងទៀតបានផងដែរ។ គ្រាន់តែហៅទូរសព្ទមកយើងតាមលេខ 1-855-670-5934 ។ អ្នកដែលនិយាយភាសា ខ្មែរ អាចជួយអ្នកបាន។ នេះជាសេវាកម្មមិនគិតថ្លៃនោះទេ។

Laotian: ພວກເຮົາມີການບໍລິການນາຍພາສາຟຣີ ສໍາລັບຜູ້ທີ່ຕ້ອງການການບໍລິການການແປພາສາ ເພື່ອຕອບຄໍາຖາມໃດໆ ຈະມີກັບສຸຂະພາບ ຫຼືແຜນການຢາຂອງພວກເຮົາ. ພວກເຮົາຍັງສາມາດໃຫ້ຂໍ້ມູນໃນພາສາລາວ ໃນຮູບແບບ ຫນາໃຫຍ່ ຫຼືຮູບແບບອື່ນ. ພຽງແຕ່ໂທຫາພວກເຮົາທີ່ 1-855-670-5934. ຄົນທີ່ເວົ້າພາສາລາວ ສາມາດຊ່ວຍທ່ານໄດ້. ນີ້ແມ່ນການບໍລິການຟຣີ.

TUFTS Health Plan

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

Tufts Health Plan:

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

If you need these services, contact Tufts Health Plan at 1-855-670-5934 (TTY: 711).

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

Tufts Health Plan, Attention:

Civil Rights Coordinator, Legal Dept.
1 Wellness Way, Canton, MA 02021
Phone: 1-888-880-8699 ext. 48000, (TTY: 711)
Fax: 1-617-972-9048
Email: OCRCoordinator@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
1-800-368-1019 (TDD: 1-800-537-7697)

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

www.thpmp.org/sco | 1-855-670-5934 (TTY: 711)

Tufts Health Plan Senior Care Options Member Services

Method	Member Services – Contact Information
CALL	1-855-670-5934 Calls to this number are free. Representatives are available 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31 and Monday - Friday from April 1 to September 30. After hours and on holidays, please leave a message and a representative will return your call on the next business day. Member Services also has free language interpreter services available for members who require translation services.
TTY	711 Calls to this number are free. Representatives are available 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31 and Monday - Friday from April 1 to September 30. After hours and on holidays, please leave a message and a representative will return your call on the next business day.
FAX	1-617-972-9487
WRITE	Tufts Health Plan Senior Care Options Attn: Member Services P.O. Box 494 Canton, MA 02021-1166
WEBSITE	www.thpmp.org/sco

SHINE (Serving the Health Information Needs of Everyone) (Massachusetts' SHIP)
SHINE is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Method	Contact Information
CALL	1-800-243-4636
TTY	1-800-439-2370 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Call the number above for the address of the SHINE program in your area.
WEBSITE	www.mass.gov/health-insurance-counseling

PRA Disclosure Statement *According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*