TUFTS MEDICARE COMPLEMENT PLAN MEMBER HANDBOOK

EFFECTIVE JULY 1, 2022

TUFTS Health Plan

Commonwealth of Massachusetts
Group Insurance Commission

Introduction

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

For more information about your coverage under the Tufts Medicare Complement Plan, see **Part I – Tufts Medicare Complement (Medical) Plan** on page 11.

Prescription Drug Benefits

Part II explains the GIC's prescription drug benefits Plan, which is administered under a separate Plan by SilverScript® Insurance Company. Your benefits, and any requirements you must follow to obtain these benefits, are described in **Part II – Prescription Drug Benefit Plan** on page 77.

Member Identification Cards

Tufts Health Plan and SilverScript® Insurance Company give each Member a separate Member Identification Card (Member ID).

Tufts Medicare Complement Plan Member ID

Tufts Health Plan gives each Member a Member Identification Card (Member ID) for this Tufts Medicare Complement Plan. If you have any questions about your Member ID, please call Member Services at 800-870-9488.

Reporting Errors:
When you receive your Member ID, check it carefully. If any information is wrong, call us at 800-870-9488.

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

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

Identifying Yourself as a Tufts Health Plan Member

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

Membership Requirement

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

CVS SilverScript® Plan Member ID

You will receive a second Member ID Card directly from CVS SilverScript for your Prescription Drug Benefit Plan. If you have questions or would like information about the formulary (list of covered drugs), call the CVS SilverScript customer relations department at 877-876-7214 or visit **http://www.gic.silverscript.com**.

Tufts Health Plan Address and Telephone Directory

TUFTS HEALTH PLAN
1 Wellness Way
Canton, Massachusetts 02021

Hours: Representatives are available Monday – Friday, 8:00 a.m. – 8:00 p.m. From October 1st - February 14th, representatives are available seven Days a week, 8:00 a.m. to 8:00 p.m.

After hours and on holidays, please leave a message and a representative will return your call the next business day.

IMPORTANT PHONE NUMBERS

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

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

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

Member Services Department
Call for general questions, including benefit questions, and information regarding eligibility for enrollment and billing: 800-870-9488.

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

- Telecommunications Device for the Deaf (TTY): If you have access to a TTY phone, call 711. You will reach Member Services.
- Massachusetts Relay (MassRelay): 711.

Fraud, Waste, and Abuse
You may have concerns about being billed for services you never received, or that your insurance information has been stolen or used by someone else. To report potential health care fraud or abuse, or if you have questions, please call us at 800-870-9488 or send an email to **fraudandabuse@tufts-health.com**. You can also call our confidential hotline any time at 877-824-7123 or send an anonymous letter to us at:

Tufts Health Plan
Attn: Fraud and Abuse
1 Wellness Way
Canton, MA 02021

IMPORTANT ADDRESSES

Appeals and Grievances Department
If you need to call us about a concern or appeal, contact Member Services at 800-870-9488. To submit your Appeal or Grievance in writing, send your letter to the address below. Or you may fax it to us at 617-972-9509.

Tufts Health Plan
Attn: Appeals and Grievances Department
P.O. Box 9193
Watertown, MA 02472-9193

You may also submit your appeal or grievance in-person at this address:

Tufts Health Plan
1 Wellness Way
Canton, MA 02021

Important Note: In many instances, we will ask you to direct your initial concern to Medicare. This is because Medicare will make the primary determination on your health care benefits. Information is available by contacting your local Social Security office or on the official Medicare website at **http://www.medicare.gov**.

WEBSITE

Tufts Health Plan Website
For more information about us and to learn more about the self-service options that are available to you, please see our website at **http://www.tuftshealthplan.com/gic**.

Translating Services For More Than 200 Languages

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

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

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

Chinese 若需免費的中文版本，請撥打 ID 卡上的電話號碼。

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

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

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

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

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

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

Khmer (Cambodian) សម្រាប់សេវាបកប្រែជាភាសាខ្មែរ ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខដែលមាននៅលើប័ណ្ណសម្គាល់សមាជិករបស់អ្នក។

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

Laotian ສໍາລັບການແປພາສາເປັນພາສາລາວທີ່ບໍ່ໄດ້ເສຍຄ່າໃຊ້ຈ່າຍ, ໃຫ້ໂທຫາເບີທີ່ຢູ່ເທິງບັດປະຈໍາຕົວຂອງທ່ານ.

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

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

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

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

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

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

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

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

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Part 1

Tufts Medicare Complement (Medical) Plan

Administered by

PART I - TUFTS MEDICARE COMPLEMENT (MEDICAL) PLAN

Chapter 1: How the Tufts Medicare Complement Plan Works

Overview

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

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

We are pleased you have chosen us. We look forward to working with you to help you meet your health care needs. Your satisfaction with us is important to us. If you have questions, please call Member Services at 800-870-9488. We will be happy to help you.

Benefits under the Plan

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

Your Member Handbook

This book, called your Member Handbook, will help you find answers to your questions about Tufts Medicare Complement Plan benefits. We certify that you have the right to services and supplies described in this Member Handbook which are:

- eligible for coverage under Medicare; or
- eligible for coverage under the Plan, when Medically Necessary.

Certain benefits described in this Member Handbook are consistent with the requirements of Massachusetts law. Medicare is the primary insurer for Medicare-Covered Services and the Plan is the secondary insurer.

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

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

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

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

Calls to Member Services

The Tufts Health Plan Member Services Department is committed to excellent service. Calls to Member Services may, on occasion, be monitored to assure quality service.

Canceling Appointments

If you must cancel an appointment with any Provider:

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

When You Need Emergency Care

Guidelines for Receiving Covered Emergency Care

Follow these guidelines when you need Emergency care within the United States:

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

For information about obtaining Emergency Care and Urgent Care services outside of the United States, please see Foreign Travel in Chapter 3 on page 23.

ALTERNATIVES TO OPIOIDS FOR PAIN MANAGEMENT

Tufts Medicare Complement (Medical) Plan – This Plan covers services and medications for pain management that are alternatives to opioids. Services include, but are not limited to:

- Chiropractic services
- Acupuncture services
- Nutrition Therapy
- Physical therapy

To find a Provider for these services, please see our website. Click on "Find a Doctor or Hospital" to start your search. You may also call Member Services for help in finding a Provider.

SilverScript® Prescription Drug Plan – This Plan covers Medications for pain management that are alternatives to opioids include, but are not limited to:

- Non-steroidal anti-inflammatory agents, such as ibuprofen; and
- Cyclooxygenase-2 (Cox-2) inhibitors, such as celecoxib.

For information about medication alternatives to opioids, please call Member Services.

Eligibility

Subscribers

- You must meet all of the requirements below to be eligible to enroll in the Plan.
- You must be enrolled in free Medicare Part A and Medicare Part B.
- You must be eligible for GIC health coverage as a state or municipal retiree, Spouse, or Dependent. And you must meet the GIC's and the Plan's eligibility rules:
  - Age 65 or older, or
  - Under age 65 and enrolled in Medicare A and B due to disability. If the disability is due to End-Stage Renal Disease (ESRD), you must satisfy the Medicare COB period to be eligible for the Plan.
- You must not be enrolled in any other Medicare supplement Plan.

We may ask you for proof of eligibility. We may also ask you for proof of your continuing eligibility. For instance, we may ask for proof of your continued enrollment in Medicare Part B.

Spouses and Dependents

Enrollees in the Plan must have Medicare Parts A and B. For a Spouse or eligible Dependent who is not covered by Medicare, your Group may offer coverage on another Plan. Contact the GIC for information on possible coverage for Spouses and eligible Dependents.

Enrollment

You must apply to the GIC to enroll in this Plan. The GIC may ask for more information about your eligibility before enrolling you in the Plan.

Effective Date of Coverage

Upon receipt of your application and required Medicare documentation, the GIC will determine the Effective Date of enrollment in the Plan.

Chapter 3: Benefit Schedule and Covered Services

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

The "Covered Services" section of this chapter describes the health care services and supplies that qualify as Covered Services under this Member Handbook. Read this section to understand your coverage under this Tufts Medicare Complement Plan option. In addition, this chapter explains the services and supplies limited or excluded under this Member Handbook. For more information, see the Limitations on Benefits section on page 52, and the Exclusions from Benefits section on page 52 at the end of this chapter.

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

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

Acupuncture

Medicare Pays	The Plan Pays	You Pay
Medicare benefits in full for acupuncture services, **except:** • The Part B Deductible; • The Part B Coinsurance.	The following charges, minus a $15 Copayment for an office visit: • The Part B Deductible; • The Part B Coinsurance.	• A $15 Copayment for an office visit.

Tufts Medicare Complement Plan Covered Services

Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for acupuncture for chronic lower back pain (lasting 12 weeks or longer) for up to 12 visits in 90 days.

Notes:

- Coverage is available for up to 20 acupuncture treatments annually.
- An additional 8 sessions will be available to patients showing improvement.
- Treatment will be discontinued if no improvement or regression occurs.
- The cause of low back pain must be:
  - A non-specific, no identifiable systemic cause (for example, not associated with metastatic, inflammatory, or infectious disease), or
  - Not associated with surgery, or
  - Not associated with pregnancy.

Allergy Testing and Treatment

Medicare Pays	The Plan Pays	You Pay
Medicare benefits in full, **except:** • The Part B Deductible; • The Part B Coinsurance.	• The Part B Deductible; • The Part B Coinsurance.	• Nothing.

Tufts Medicare Complement Plan Covered Services

Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for Medicare-approved allergy testing and treatment.

Ambulance Services

Medicare Pays	The Plan Pays	You Pay
Medicare benefits in full, **except**: • The Part B Deductible; • The Part B Coinsurance.	• The Part B Deductible; • The Part B Coinsurance.	• Nothing.

Tufts Medicare Complement Plan Covered Services

Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for:

- Medicare-approved transportation in an ambulance to an Emergency medical facility for treatment of an Accident or for Emergency medical care.
- Other Medically Necessary ambulance transportation approved by Medicare.

Autism Spectrum Disorders – Diagnosis and Treatment

Medicare Pays	The Plan Pays	You Pay
When covered by Medicare: Medicare benefits in full, **except:** • The Part B Deductible; • The Part B Coinsurance. **When not covered by Medicare:** • Nothing	**For rehabilitative or habilitative care (including applied behavioral analysis):** **When not covered by Medicare:** Benefits in full, minus a $15 Copayment per visit for services from a Paraprofessional or a $15 Copayment per visit for services from a Board-Certified Behavior Analyst (BCBA). **For prescription medications:** Nothing. You must have Medicare Part D coverage, which is offered under a separate Prescription Drug Plan administered by CVS SilverScript®. For more information, call 877-876-7214 or visit **http://www.gic.silverscript.com**. **For psychiatric/psychological care:** See the Mental Health and Substance Abuse Services benefit on page 28. **Therapeutic care:** See Short Term Rehabilitation Therapy (Physical, Occupational, & Speech-Language) benefit on page 42.	**When covered by Medicare:** • Nothing. **When not covered by Medicare:** • Nothing, for rehabilitative or habilitative care. • For services from a Paraprofessional: a $15 Copayment per visit. • For services from a Board-Certified Behavior Analyst: a $15 Copayment per visit. • All charges for all other services.

Tufts Medicare Complement Plan Covered Services
Coverage is provided, in accordance with applicable law, for the diagnosis and treatment of autism spectrum disorders. Autism spectrum disorders include any of the pervasive developmental disorders, as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, and include: • autistic disorder; • Asperger's disorder; and • pervasive developmental disorders not otherwise specified. Coverage is provided, up to the Allowed Charge, for the following Covered Services: • habilitative or rehabilitative care, which are professional counseling and guidance services and treatment programs that are necessary to develop, maintain, and restore the functioning of the individual. These programs may include, but are not limited to, applied behavioral analysis (ABA) supervised by a Board-Certified Behavior Analyst (BCBA). For more information about these programs, call the Tufts Health Plan Mental Health Department at 800-208-9565; • services provided by licensed or certified speech therapists, occupational therapists, physical therapists, or social workers; • psychiatric and psychological care, covered under your Mental Health and Substance Abuse Services benefit; and • therapeutic care (including services provided by licensed or certified speech therapists, occupational therapists, physical therapists, or social workers), covered under your Short Term Rehabilitation Therapy (Physical, Occupational, & Speech-Language) benefit. **Notes:** • Prescription medications to treat autism spectrum disorders are covered under Medicare Part D. You will need to enroll in Medicare Part D to receive coverage for these drugs. Medicare Part D coverage is offered under a separate Prescription Drug Plan administered by CVS SilverScript®. For more information, call 877-876-7214 or visit **http://www.gic.silverscript.com**. • For the purposes of this benefit, ABA includes the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Blood Services – Inpatient

Medicare Pays	The Plan Pays	You Pay
Medicare benefits in full, **except:** • The blood Deductible. This Deductible is for the first 3 pints of un-replaced blood during a calendar year.	• The blood Deductible.	• Nothing.

Tufts Medicare Complement Plan Covered Services

The Plan provides coverage for the Inpatient blood Deductible under Medicare Part A. This Deductible is the cost of the first three pints of blood you use in a calendar year as an Inpatient in a Hospital or Skilled Nursing Facility.

Note: The Inpatient blood Deductible will only apply to you if the Hospital or Skilled Nursing Facility has to purchase the blood for you for your Inpatient admission. In this case, this Deductible will be waived if you either replace the blood yourself or have it donated by another party.

See also Blood Services - Outpatient on page 18. You are only responsible for paying one blood Deductible under Medicare Part A or Part B per calendar year.

Blood Services – Outpatient

Medicare Pays	The Plan Pays	You Pay
Medicare benefits in full, **except:** • The blood Deductible.	• The blood Deductible.	• Nothing.

Tufts Medicare Complement Plan Covered Services

The Plan provides coverage for the Outpatient blood Deductible under Medicare Part B. This Deductible is the cost of the first three pints of blood you use in a calendar year as an Outpatient at a Hospital.

Note: The Outpatient blood Deductible will only apply to you if the Hospital has to purchase the blood for you for your Outpatient services. In this case, this Deductible will be waived if you either replace the blood yourself or have it donated by another party.

See also Blood Services - Inpatient on page 18 above. You are only responsible for paying one blood Deductible under Medicare Part A or Part B per calendar year.

Cardiac Rehabilitation Services

Medicare Pays	The Plan Pays	You Pay
Medicare benefits in full, **except:** • The Part B Deductible; • The Part B Coinsurance.	• The Part B Deductible; • The Part B Coinsurance.	• Nothing.

Tufts Medicare Complement Plan Covered Services

Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for Medicare-approved Outpatient cardiac rehabilitation services.

Chemotherapy

Medicare Pays	The Plan Pays	You Pay
Medicare benefits on an Inpatient basis as described under Hospital Medical and Surgical Care – Inpatient.	As described under Hospital Medical and Surgical Care – Inpatient.	As described under Hospital Medical and Surgical Care – Inpatient.
Medicare benefits on an Outpatient basis as described under Hospital Medical and Surgical Care – Outpatient.	As described under Hospital Medical and Surgical Care – Outpatient.	As described under Hospital Medical and Surgical Care – Outpatient.

Tufts Medicare Complement Plan Covered Services

Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for Inpatient and Outpatient chemotherapy for cancer patients.

Chiropractor Services

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

Tufts Medicare Complement Plan Covered Services

Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for manual manipulation of the spine. This benefit must be furnished: (1) by a chiropractor; and (2) to correct a subluxation of the spine.

Diabetic Services and Supplies

Medicare Pays	The Plan Pays	You Pay
When covered by Medicare: Medicare benefits in full, **except:** • The Part B Deductible; • The Part B Coinsurance. **When not covered by Medicare:** • Nothing.	**When covered by Medicare:** • The Part B Deductible; • The Part B Coinsurance. **When not covered by Medicare:** • Nothing.	**When covered by Medicare:** • Nothing. **When not covered by Medicare:** • All charges.

Tufts Medicare Complement Plan Covered Services

Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for certain Medicare-approved Part B diabetes supplies. These supplies include such items as: blood sugar (glucose) test strips; blood sugar monitors (glucometers); lancet devices and lancets; glucose control solutions for checking test strip and monitor accuracy; and therapeutic shoes or inserts for Members with severe diabetic foot disease.

Notes:

- Part B diabetes supplies are covered under the Durable Medical Equipment benefit on page 21.
- The following diabetes-related drugs and supplies are **not covered** by either Medicare or this Plan: insulin (unless used with an insulin pump); insulin pens; syringes; needles; alcohol swabs; or gauze. Insulin and certain medical supplies used to inject insulin, such as syringes, gauze, and alcohol swabs are covered under your separate Prescription Drug Plan.
- Your Prescription Drug coverage is Medicare Part D coverage offered under a separate Prescription Drug Plan administered by SilverScript®. For more information, call 877-876-7214 or visit **http://www.gic.silverscript.com**.

Diagnostic Tests, X-rays, and Clinical Laboratory Services

Medicare Pays	The Plan Pays	You Pay
Medicare benefits in full**, except:** • The Part B Deductible; • The Part B Coinsurance.	• The Part B Deductible; • The Part B Coinsurance.	• Nothing for MRI, CAT scan, and PET scan diagnostic radiological services.

Tufts Medicare Complement Plan Covered Services

Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for Medicare-approved Outpatient diagnostic tests, X-rays, and clinical laboratory services.

Dialysis (Kidney) Services and Supplies		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits in full, **except:** • The Part B Deductible; • The Part B Coinsurance.	• The Part B Deductible; • The Part B Coinsurance.	• Nothing.
Tufts Medicare Complement Plan Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for Medicare-approved Outpatient maintenance dialysis treatment services and self-dialysis training, as well as certain home dialysis treatment services.		

Durable Medical Equipment and Prosthetic Devices		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits in full, **except:** • The Part B Deductible; • The Part B Coinsurance.	• The Part B Deductible; • The Part B Coinsurance.	• Nothing.
Tufts Medicare Complement Plan Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for Medicare-approved Durable Medical Equipment and prosthetic devices (including some types of breast prostheses after a mastectomy).		

Emergency Room and Urgent Care		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits in full for Emergency Room care, **except:** • The Part B Deductible; • The Part B Coinsurance.	The following charges, minus a $50 Copayment for Emergency Room Care (if not admitted): • The Part B Deductible; • The Part B Coinsurance.	• A $50 Copayment for Emergency Room Care (if not admitted).
Medicare benefits in full for Urgent Care services, **except:** • The Part B Deductible; • The Part B Coinsurance.	The following charges, minus a $15 Copayment for an office visit: • The Part B Deductible; • The Part B Coinsurance.	• A $15 Copayment for an office visit.

Tufts Medicare Complement Plan Covered Services
Urgent Care services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Once Medicare approves the coverage, the Plan provides coverage up to the Allowed Charge for Medicare-approved Emergency Room and Urgent Care services within the United States. You do not pay the Copayment if you are admitted as an Inpatient to the Hospital within 24 hours for the same condition. **Notes:** • At the onset of a medical condition that you judge to be an Emergency, go to the nearest Emergency medical facility. For more information, see Guidelines for Receiving Covered Emergency Care on page 12 in Chapter 1. • An Emergency Room Copayment may apply if you register in an Emergency Room but leave that facility without receiving care. • Observation services will take an Emergency Room Copayment.

Enteral Formulas, Low Protein Food Products

Medicare Pays	**The Plan Pays**	**You Pay**
When covered by Medicare: Medicare benefits in full, **except:** • The Part B Deductible; • The Part B Coinsurance. **When not covered by Medicare:** • Nothing.	**When covered by Medicare:** • The Part B Deductible; • The Part B Coinsurance. **When not covered by Medicare:** • For certain enteral formulas, benefits in full. • For low protein food products, benefits in full up to $5,000 per calendar year.	**When covered by Medicare:** • Nothing. **When not covered by Medicare:** • Nothing for certain enteral formulas. • All charges for low protein food products after the Plan pays $5,000 in a calendar year.

Tufts Medicare Complement Plan Covered Services
The Plan provides coverage up to the Allowed Charge for the following formulas and food products: • Enteral formulas for home use for treatment of malabsorption caused by: Crohn's disease; ulcerative colitis; gastroesophageal reflux; gastrointestinal motility; chronic intestinal pseudo-obstruction; and inherited diseases of amino acids and organic acids. The Plan covers these formulas in full up to their Allowed Charge. • Food products modified to be low protein when Medically Necessary to treat inherited diseases of amino acids and organic acids. Note that Medicare does not cover these food products. The Plan covers these products up to a maximum of $5,000 per calendar year. You are responsible for paying any additional charges for these products in a calendar year.

Foreign Travel		
Medicare Pays	**The Plan Pays**	**You Pay**

• Nothing for Emergency Room and Urgent Care services received outside the United States.	• All expenses Medicare would have paid for if the services had been received in the United States,
	  • plus the Medicare Part A and B Deductible and Coinsurance; and
	  • the remainder of charges, minus a $50 Copayment for Emergency Room Care (if not admitted) or a $15 Copayment for an office visit.
		• The appropriate Cost-Share depending on the services rendered:
		  • a $50 Copayment for Emergency Room Care (if not admitted); or
		  • a $15 Copayment for an office visit.

Tufts Medicare Complement Plan Covered Services

Urgent Care services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care.

Medicare generally **does not** cover services that you receive while traveling outside of the United States and its territories. For more information on this topic, please refer to your Medicare Handbook.

For Emergency Room and Urgent Care services that **Medicare would have covered** if you received them in the United States, the Plan provides benefits for both:

- the Covered Services listed in this Member Handbook; and
- the benefits that Medicare normally provides that are listed in this Member Handbook.

Notes:

- The Plan will **not** pay for any services if you establish residency outside of the United States or its territories.
- An Emergency Room Copayment may apply if you register in an Emergency Room but leave that facility without receiving care.
- Observation services will take an Emergency Room Copayment.

Home Health Care

Medicare Pays	The Plan Pays	You Pay
For Medicare covered home visits: Medicare benefits in full, **except:** • The Part B Deductible; • The Part B Coinsurance.	• The Part B Deductible; • The Part B Coinsurance.	• Nothing.

Tufts Medicare Complement Plan Covered Services

Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for Medicare-approved home health care services.

Note: The Plan also provides coverage up to the Allowed Charge for Durable Medical Equipment required as part of Medicare-approved home health care services. This coverage is provided once Medicare provides benefits for this equipment.

Hospice Care

Medicare Pays	The Plan Pays	You Pay
When covered by Medicare: • Medicare benefits in full for most services. **When not covered by Medicare:** • Nothing.	**When Medicare does not provide benefits in full:** • The difference between the amount Medicare pays and the Allowed Charge. **When not covered by Medicare:** • Covered Services in full.	**When covered by Medicare:** • Nothing. **When not covered by Medicare:** • Nothing.

Tufts Medicare Complement Plan Covered Services

If Medicare does not provide either full benefits or any benefits for hospice care services, the Plan provides coverage up to the Allowed Charge for the following hospice care services required for a terminally ill person (a person with a life expectancy of six months or less) under Massachusetts law:

- the following services when they are either provided or arranged by a hospice care Provider: Physician services; nursing care provided by or supervised by a registered professional nurse; social work services; volunteer services; home health aide services; counseling services; Durable Medical Equipment; and drugs;
- respite care (care for the terminally ill person to provide relief to the family or other person providing primary care to that person); and
- bereavement counseling services for the Member's family.

Hospital Medical and Surgical Care – Inpatient		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits in full in a **general Hospital facility per Benefit Period**, **except:** • The Part A Deductible for days 1-60; • The Part A Coinsurance for days 61-90; • The Part A Coinsurance for 60 lifetime Reserve days.	**Per Benefit Period:** • The Part A Deductible for days 1-60; • The Part A Coinsurance for days 61-90; • The Part A Coinsurance for 60 lifetime Reserve days; • Covered Services in full up to an additional 365 days per lifetime after Medicare benefits are used up.	**Per Benefit Period:** • Nothing for days 1-90; • Nothing for up to 60 lifetime Reserve days; • Nothing for Covered Services up to an additional 365 days per lifetime after Medicare benefits are used up; • Then, all charges.
Medicare benefits in full for **Physician and other professional Provider services**, **except:** • The Part B Deductible; • The Part B Coinsurance.	• The Part B Deductible; • The Part B Coinsurance.	• Nothing.
Tufts Medicare Complement Plan Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for all Medicare-approved Inpatient days during a Benefit Period. This Tufts Medicare Complement Plan coverage is provided for: • the 1st 60 days of a Benefit Period; • the 61st through 90th days of a Benefit Period; and • the 60 lifetime Medicare Reserve days. Once you have used up all of your Medicare Reserve days, the Plan provides coverage up to the Allowed Charge for an additional 365 lifetime Inpatient days. These additional days are only covered for semi-private room and board charges. **Note:** Neither the Plan nor Medicare covers private duty nursing services.		

Hospital Medical and Surgical Care - Outpatient (including Ambulatory Surgical Centers)		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits in full in a **general Hospital facility or Ambulatory Surgical Center**, **except:** • The Part B Deductible; • The Part B Coinsurance.	• The Part B Deductible; • The Part B Coinsurance.	• Nothing.
Medicare benefits in full for **Physician and other professional Provider services**, **except:** • The Part B Deductible; • The Part B Coinsurance.	• The Part B Deductible; • The Part B Coinsurance.	• Nothing.
Tufts Medicare Complement Plan Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for Medicare-approved Outpatient Hospital and medical care including: Physician services; Outpatient medical services and supplies; physical and speech therapy; diagnostic tests; and Durable Medical Equipment. Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for Outpatient surgical care provided in a Medicare-approved facility (for example, a general Hospital or an Ambulatory Surgical Center).		

Human Organ Transplants

Medicare Pays	The Plan Pays	You Pay
Medicare benefits on an Inpatient basis as described under Hospital Medical and Surgical Care – Inpatient. Medicare benefits on an Outpatient basis as described under Hospital Medical and Surgical Care – Outpatient.	As described under Hospital Medical and Surgical Care – Inpatient. As described under Hospital Medical and Surgical Care – Outpatient.	As described under Hospital Medical and Surgical Care – Inpatient. As described under Hospital Medical and Surgical Care – Outpatient.

Tufts Medicare Complement Plan Covered Services

Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for Medicare-approved human organ transplants.

- Medicare Part A provides coverage under certain conditions and only at Medicare-approved facilities for transplants of the: heart; lung; kidney; pancreas; intestine; and liver.
- Medicare Part B provides coverage for cornea and bone marrow transplants.

For more information about this coverage under Medicare Part A and Part B, see your Medicare Handbook or contact Medicare.

Medical Care Outpatient Visits by a Physician or Covered Practitioner (Non-physician)

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

Tufts Medicare Complement Plan Covered Services

Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for Medicare-approved medical care used to diagnose or treat an illness or injury such as:

- office, home, or clinic visits;
- medical nutrition therapy services;
- hormone replacement therapy for peri- and post-menopausal women;
- follow-up medical care following an Accidental injury or an Emergency.

Note: This benefit includes coverage for psychological services and neuropsychological assessment services.

Mental Health and Substance Abuse Services		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits in full for **Inpatient stay in a general Hospital, except:** **Per Benefit Period:** • The Part A Deductible for days 1-60; • The Part A Coinsurance for days 61-90; • The Part A Coinsurance for 60 lifetime Reserve days.	**Inpatient stay in a general Hospital:** **Per Benefit Period:** • The Part A Deductible for days 1-60; • The Part A Coinsurance for days 61-90; • The Part A Coinsurance for 60 lifetime Reserve days; • Covered Services in full up to an additional 365 Days per lifetime after Medicare benefits are used up.	**Inpatient stay in a general Hospital:** **Per Benefit Period:** • Nothing for days 1-90; • Nothing for up to 60 lifetime Reserve days; • Nothing for Covered Services up to an additional 365 days per lifetime after Medicare days are used up; • Then, all charges.
Medicare benefits in full for **Inpatient stay in a mental Hospital, except:** **Per Benefit Period:** • The Part A Deductible for days 1-60; • The Part A Coinsurance for days 61-90; • The Part A Coinsurance for 60 lifetime Reserve days. **Note:** Medicare benefits in a mental Hospital are limited to 190 days per lifetime.	**Inpatient stay in a mental Hospital:** **Per Benefit Period:** • The Part A Deductible for days 1-60; • The Part A Coinsurance for days 61-90; • The Part A Coinsurance for 60 lifetime Reserve days; • Covered Services in full up to 120 additional days per Benefit Period in a mental Hospital, less any days in a mental Hospital already covered by Medicare or the Plan in that Benefit Period or calendar year.	**Inpatient stay in a mental Hospital:** **Per Benefit Period:** • Nothing for days 1-90; • Nothing for up to 60 lifetime Reserve days; • Covered Services up to 120 days per Benefit Period in a mental Hospital; • Then, all charges.

Mental Health and Substance Abuse Services - continued		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits in full for **Inpatient Physician and other covered professional mental health Provider services** for as many days as Medically Necessary, **except:** • The Part B Deductible; • The Part B Coinsurance.	**Inpatient Physician and other covered professional mental health Provider services** covered by Medicare and the Plan for as many days as Medically Necessary in a general Hospital: • The Part B Deductible; • The Part B Coinsurance; • Covered Services in full for as many days as Medically Necessary in a general Hospital and up to 120 additional days per Benefit Period in a mental Hospital when covered only by the Plan.	**Inpatient Physician and other covered professional mental health Provider services:** • Nothing for as many days as Medically Necessary.
Medicare benefits in full for Medically Necessary **Outpatient treatment, <u>except</u>:** • The Part B Deductible; • The Part B Coinsurance.	**Outpatient treatment** for as many visits as Medically Necessary: …the following charges, minus a $15 Copayment per visit: • The Part B Deductible; • The Part B Coinsurance; • Covered Services in full when provided only by the Plan, minus a $15 Copayment per visit.	**Outpatient treatment** for as many visits as Medically Necessary: • A $15 Copayment per visit for Medicare and Plan benefits for as many visits as Medically Necessary; • A $15 Copayment per visit when covered only by the Plan.

Tufts Medicare Complement Plan Covered Services

Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for Outpatient services provided by a mental health care Provider. If Medicare does not provide coverage, the Plan provides coverage up to the Allowed Charge for Inpatient services provided by a Physician specializing in psychiatry, a psychologist, a licensed independent clinical social worker, a clinical specialist in psychiatric and mental health nursing, or a licensed mental health counselor. The Plan provides this coverage for as many visits as are Medically Necessary.

Note: Coverage of other, non-mental health treatment of autism and autism spectrum disorders is described under Autism spectrum disorders – diagnosis and treatment on page 16.

The Plan provides coverage up to the Allowed Charge for Medicare-approved Inpatient Mental Health and Substance Abuse Services:

- Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for all Medicare-approved Inpatient days during a Benefit Period. The Plan coverage is provided for:
  - the 1st 60 days of a Benefit Period;
  - the 61st through 90th day of a Benefit Period; and
  - the 60 lifetime Reserve days.

Once you have used up all of your Reserve days, the Plan provides coverage up to the Allowed Charge for an additional 365 lifetime Inpatient days. These additional days are only covered for semi-private room and board charges.

Note: These limits also apply to all other Inpatient stays. For more information, see the benefit description for Hospital Medical and Surgical Care - Inpatient on page 25.

The Plan provides coverage up to the Allowed Charge under this benefit for:

- Up to 120 days per Benefit Period. This may occur when your Inpatient days are covered by Medicare or the Plan during a Benefit Period (or in the same calendar year).
- Up to a total of 365 lifetime Inpatient days.

Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for Outpatient services provided by a Physician specializing in psychiatry or a psychologist. If Medicare does not provide coverage, the Plan provides coverage up to the Allowed Charge for Inpatient services provided by a Physician specializing in psychiatry, a psychologist, or a clinical specialist in psychiatric and mental health nursing.

Intermediate Mental Health Care Services

In certain instances, you may need Covered Services that are more intensive than Outpatient services (but not requiring a 24-hour Inpatient Hospital admission). Both Medicare and the Plan cover these intermediate mental health care services. As a result, Medicare will decide whether this care is Medically Necessary for you. These services include, but are not limited to: intensive Outpatient programs; acute residential; and partial Hospital programs.

Opioid treatment program services

Medicare Pays	The Plan Pays	You Pay
Medicare benefits in full.	• Nothing.	• Nothing.

Tufts Medicare Complement Plan Covered Services

Covered Services include:
- FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable;
- Substance use counseling;
- Individual and group therapy; and
- Toxicology testing.

Oxygen and Equipment

Medicare Pays	The Plan Pays	You Pay
Medicare benefits in full, **except:** • The Part B Deductible; • The Part B Coinsurance.	• The Part B Deductible; • The Part B Coinsurance.	• Nothing.

Tufts Medicare Complement Plan Covered Services

Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for:
- the rental of oxygen equipment; and
- oxygen contents and supplies for the delivery of oxygen.

Podiatry

Medicare Pays	The Plan Pays	You Pay
Medicare benefits in full, **except:** • The Part B Deductible; • The Part B Coinsurance.	• The Part B Deductible; • The Part B Coinsurance, minus a $15 Copayment per visit.	• A $15 Copayment per visit.

Tufts Medicare Complement Plan Covered Services

Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for:
- Treatment of injuries and diseases of the feet (such as hammer toes and spurs); and
- Routine foot care* for Members with certain medical conditions affecting the lower limbs.

*For information about foot care related to diabetes, see the Diabetic Services and Supplies benefit on page 20.

Prescription Drugs – Limited Outpatient Drug Coverage under Medicare Part B

Medicare Pays	The Plan Pays	You Pay
When covered by Medicare: Medicare benefits in full, **except:** • The Part B Deductible; • The Part B Coinsurance.	**When covered by Medicare:** • The Part B Deductible; • The Part B Coinsurance.	**When covered by Medicare:** • Nothing.

Tufts Medicare Complement Plan Covered Services

Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for a limited number of Outpatient prescription drugs covered under Medicare Part B. Some examples include certain drugs in the following categories:

- osteoporosis drugs;
- injectable drugs given by a licensed medical practitioner; and
- oral anti-nausea drugs.

For more information about this Part B benefit, see your Medicare Handbook or contact Medicare.

Note: This Plan **does not** pay for most prescription drugs. You pay the full cost for most prescription drugs. In order to receive the full prescription drug benefits available through Medicare, you need to enroll in the GIC's Prescription Drug Plan. That Medicare Part D coverage is offered under a separate Prescription Drug Plan administered by CVS SilverScript®. For more information, call 877-876-7214 or visit **http://www.gic.silverscript.com**.

Preventive Care – Abdominal aortic aneurysm screening

Medicare Pays	The Plan Pays	You Pay
Medicare benefits in full.	• Nothing.	• Nothing.

Tufts Medicare Complement Plan Covered Services

Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for a one-time screening ultrasound for people at risk.

Note: This screening is only covered for Members with certain risk factors.

Preventive Care – Alcohol Screening and counseling to reduce alcohol misuse

Medicare Pays	The Plan Pays	You Pay
Medicare benefits in full.	• Nothing.	• Nothing.

Tufts Medicare Complement Plan Covered Services

Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol but are not alcohol dependent.

Note: After screening positive for alcohol misuse, a Member is eligible to receive up to 4 brief face-to-face counseling sessions per year (if the Member is competent and alert during counseling).

Preventive Care – Annual Prostate Cancer Screenings

Medicare Pays	The Plan Pays	You Pay

Medicare benefits as follows for annual prostate cancer screenings:
• Full benefit for annual Prostate-Specific Antigen (PSA) test.
• Annual digital rectal exam covered, subject to:
  • The Part B Deductible;
  • The Part B Coinsurance.
	When covered by Medicare:
	• Nothing.
	• The Part B Deductible;
	• The Part B Coinsurance.
		When covered by Medicare:
		• Nothing.
		• Nothing.

Tufts Medicare Complement Plan Covered Services

Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for the following routine prostate cancer screenings:

- Digital rectal exam: one exam per year for Members aged 50 or older.
- PSA blood test: one test per year for Members aged 50 or older.

Note: The Plan may also provide coverage up to the Allowed Charge for additional prostate cancer screenings determined by Medicare to be Medically Necessary.

Preventive Care – Annual Screening Mammograms

Medicare Pays	The Plan Pays	You Pay
Medicare benefits in full for annual screening mammogram.	• Nothing.	• Nothing.

Tufts Medicare Complement Plan Covered Services

Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for mammograms as follows:

- One baseline mammogram for a Member between ages 35 and 39.
- One routine mammogram each calendar year for a Member aged 40 or older.

Note: The Plan also provides coverage up to the Allowed Charge for Medically Necessary diagnostic mammograms. For more information, see Diagnostic Tests, X-rays, and Clinical Laboratory Services on page 20.

Preventive Care – Annual Wellness Exam

Medicare Pays	The Plan Pays	You Pay
Medicare benefits in full for an annual wellness exam. **Note:** This benefit applies in years following the initial Welcome to Medicare physical exam.	• Nothing.	• Nothing.

Tufts Medicare Complement Plan Covered Services

Medicare provides coverage for an annual wellness exam. This benefit applies in years following the initial one-time "Welcome to Medicare" physical exam, which is covered within twelve months of joining Medicare.

Preventive Care – Bone Mass Density Testing

Medicare Pays	The Plan Pays	You Pay
Medicare benefits in full for bone mass density testing.	• Nothing.	• Nothing.

Tufts Medicare Complement Plan Covered Services

Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for Medicare-approved bone mass density testing. This testing is provided to: identify bone mass; determine bone quality; or detect bone loss.

For more information, see your Medicare Handbook or contact Medicare.

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

Preventive Care – Colorectal Cancer Screenings		
Medicare Pays	**The Plan Pays**	**You Pay**

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

Tufts Medicare Complement Plan Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for the following routine colorectal cancer services: • Guaiac-based fecal occult blood test (gFOBT) or Fecal immunochemical test (FIT): one test per year for Members aged 50 or older. • Flexible Sigmoidoscopy: one test every four years for Members aged 50 or older. • Colonoscopy: one test every two years for Members determined by Medicare to be at high risk for developing colorectal cancer. • Colonoscopy: one test every ten years for Members determined by Medicare not to be at high risk of colorectal cancer, but not within four years of a screening sigmoidoscopy. • Barium Enema: one test every four years for Members aged 50 or older. • DNA based colorectal screening every three years.		

Preventive Care – Depression Screening		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits in full.	• Nothing.	• Nothing.
Tufts Medicare Complement Plan Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for a Depression screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.		

Preventive Care – Diabetes Self-Management Training		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits in full for diabetes self-management training, **except:** • The Part B Deductible; • The Part B Coinsurance.	…the following charges, minus a $15 Copayment per visit: • The Part B Deductible; • The Part B Coinsurance.	• A $15 Copayment per visit.
Tufts Medicare Complement Plan Covered Services		
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for Outpatient self-management training and educational services, including medical nutrition therapy used to diagnose or treat: insulin-dependent diabetes; non-insulin dependent diabetes; or gestational diabetes.		

Preventive Care – Family-Planning

Medicare Pays	The Plan Pays	You Pay
For Family-Planning: • Nothing.	• Benefits in full as required by state mandate.	• Nothing.

Tufts Medicare Complement Plan Covered Services

The Plan provides coverage up to the Allowed Charge for the following Family-Planning services:

- Consultations, examinations, procedures, and medical services, which are related to the use of all contraceptive methods that have been approved by the United States Food and Drug Administration (USFDA).
- The injection of birth control drugs, including a prescription drug obtained from the Provider during an office visit.
- Genetic counseling.
- Insertion of implantable contraceptives, including levonorgestrel implants. Coverage includes the implant system as well.
- Intrauterine devices (IUDs), diaphragms, and any other USFDA-approved contraceptive methods, when these contraceptives are obtained from the Provider during an office visit.

Preventive Care – Glaucoma Testing

Medicare Pays	The Plan Pays	You Pay
Medicare benefits in full for glaucoma testing, **except:** • The Part B Deductible; • The Part B Coinsurance.	• The Part B Deductible; • The Part B Coinsurance.	• Nothing.

Tufts Medicare Complement Plan Covered Services

Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for one glaucoma test every 12 months. This coverage is for Members that Medicare decides to be at high risk for glaucoma.

Preventive Care – HIV Screenings

Medicare Pays	The Plan Pays	You Pay
Medicare benefits in full.	• Nothing.	• Nothing.

Tufts Medicare Complement Plan Covered Services

Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for HIV screenings.

Notes:

- For Members who ask for an HIV screening test or who are at increased risk for HIV infection, one screening exam will be covered every 12 months.
- For women who are pregnant, up to three screening exams will be covered during a pregnancy.

Preventive Care – Medical Nutrition Therapy

Medicare Pays	The Plan Pays	You Pay
Medicare benefits in full for Medical Nutrition Therapy.	• Nothing.	• Nothing.

Tufts Medicare Complement Plan Covered Services

Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for Medicare-approved medical nutritional therapy services for Members with diabetes or kidney disease.

Preventive Care – Medicare Diabetes Prevention Program (MDPP)

Medicare Pays	The Plan Pays	You Pay
Medicare benefits in full for the Medicare Diabetes Prevention Program.	• Nothing.	• Nothing.

Tufts Medicare Complement Plan Covered Services

MDPP services are covered for eligible Medicare beneficiaries under all Medicare health Plans.

MDPP is a structured health behavioral change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.

Preventive Care – Pelvic and Clinical Breast Exams and Routine Cytology Exam (Pap Smears)

Medicare Pays	The Plan Pays	You Pay
Medicare benefits in full for pelvic, pap smear, and clinical breast exams.	• Nothing.	• Nothing.
Medicare benefits in full for a Pap smear test every two years.	• All charges for an annual routine Pap smear test each calendar year (covered in years when Medicare benefits do not cover this test).	• Nothing.

Tufts Medicare Complement Plan Covered Services

Medicare-covered exams and tests: Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for one gynecological exam (including a routine Pap smear) every two years. This coverage is provided every year for a Member that Medicare determines to be at high risk for developing cervical or vaginal cancer.

Non-Medicare-covered exams and tests: If Medicare does not provide coverage for a routine cytological exam (pap smear) per calendar year, the Plan provides full coverage up to the Allowed Charge for that exam.

Preventive Care – Screening for Lung Cancer with Low Dose Computed Tomography (LDCT)

Medicare Pays	The Plan Pays	You Pay
Medicare benefits in full for screening for lung cancer with low dose computed tomography (LDCT).	• Nothing.	• Nothing.

Tufts Medicare Complement Plan Covered Services
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for screening for lung cancer with low dose computed tomography (LDCT). **Note:** For qualified Members, a LDCT is covered every 12 months. **Eligible Members are:** people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years or who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a Physician or qualified non-Physician practitioner. **For LDCT lung cancer screenings after the initial LDCT screening:** the Member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a Physician or qualified non-Physician practitioner. If a Physician or qualified non-Physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits. **Note:** There is no Coinsurance, Copayment, or Deductible for the Medicare covered counseling and shared decision-making visit or for the LDCT.

Preventive Care – Smoking and Tobacco Use Cessation Counseling

Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits in full for a Medicare-approved smoking cessation program for Members who have not been diagnosed with an illness caused or complicated by tobacco use.	• Nothing.	• Nothing.

Tufts Medicare Complement Plan Covered Services
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for a Medicare-approved smoking cessation program. This coverage includes up to 8 face-to-face visits in a 12-month period.

Preventive Care – "Welcome to Medicare" Visit (One Time)

Medicare Pays	The Plan Pays	You Pay
Medicare benefits in full for a one-time physical exam within 12 months after Part B coverage begins.	• Nothing.	• Nothing.

Tufts Medicare Complement Plan Covered Services

Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for a one-time "Welcome to Medicare" visit.

Note: Medicare covers this exam when a Member receives it within 12 months after enrolling in Medicare Part B.

Pulmonary Rehabilitation Services (COPD)

Medicare Pays	The Plan Pays	You Pay
Medicare benefits in full for pulmonary rehabilitation services, **except:** • The Part B Deductible; • The Part B Coinsurance.	The following charges, minus a $15 Copayment for an office visit: • The Part B Deductible; • The Part B Coinsurance.	• A $15 Copayment for an office visit.

Tufts Medicare Complement Plan Covered Services

Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for comprehensive programs of pulmonary rehabilitation, which are covered for Members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.

Radiation and X-ray Therapy

Medicare Pays	The Plan Pays	You Pay
Medicare benefits in full, **except:** • The Part B Deductible; • The Part B Coinsurance.	• The Part B Deductible; • The Part B Coinsurance.	• Nothing.

Tufts Medicare Complement Plan Covered Services

Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for radiation and x-ray therapy.

Second Opinions

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

Tufts Medicare Complement Plan Covered Services

Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for: (1) an Outpatient second opinion regarding your medical care; or (2) a second surgical opinion. Coverage may also be provided for a third opinion, when the second opinion is different from the initial opinion.

Short Term Rehabilitation Therapy (Physical, Occupational, & Speech-Language)

Medicare Pays	The Plan Pays	You Pay
Medicare benefits in full, **except:** • The Part B Deductible; • The Part B Coinsurance.	…the following charges, minus a $15 Copayment per visit: • The Part B Deductible; • The Part B Coinsurance.	• A $15 Copayment per visit.

Tufts Medicare Complement Plan Covered Services

Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for Outpatient short-term rehabilitation therapy. This coverage includes: physical therapy; occupational therapy; and speech therapy.

Also, the Plan provides coverage for Medically Necessary services required to diagnose and treat speech, hearing, and language disorders.

Skilled Nursing Facility Services

Medicare Pays	The Plan Pays	You Pay
Medicare benefits **per Benefit Period:** • In full for days 1-20; • In full for days 21-100, except for the Part A Coinsurance; • Nothing for days 101-365; • Nothing for days 366 and beyond.	**Per Benefit Period:** • Nothing. • The Part A Coinsurance. • Nothing. • Nothing.	**Per Benefit Period:** • Nothing. • Nothing. • All costs. • All costs.

Tufts Medicare Complement Plan Covered Services

Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for Skilled Nursing Facility services. This coverage is provided through the 100th Day in a Benefit Period.

Note: Medicare and the Plan both provide coverage for Skilled Nursing Facility services, when a Member's Inpatient stay in such a facility meets Medicare's rules. These rules include Medicare's requirement that the Member: (1) be an Inpatient in a Hospital for at least three days; and then (2) transfer to the Skilled Nursing Facility within 30 days after leaving that Hospital.

Surgery as an Outpatient

Medicare Pays	The Plan Pays	You Pay
Medicare benefits in full, **except:** • The Part B Deductible; • The Part B Coinsurance.	As described under Hospital Medical and Surgical Care – Outpatient.	As described under Hospital Medical and Surgical Care – Outpatient.

Tufts Medicare Complement Plan Covered Services

Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for Medicare-approved Outpatient surgery.

Telehealth

Medicare Pays	The Plan Pays	You Pay
Medicare benefits in full for telehealth services, **except:** • The Part B Deductible; • The Part B Coinsurance.	The following charges, minus a $15 Copayment for an office visit: • The Part B Deductible; • The Part B Coinsurance.	• A $15 Copayment for an office visit.

Tufts Medicare Complement Plan Covered Services
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for Medicare-approved telehealth services. Additional services may be provided (outside of Part B) under this plan. For more information, see Telemedicine under the Additional Covered Services Provided by the Plan section of Chapter 3. **Note:** The Plan provides coverage for services like office visits, psychotherapy, consultations, and certain other medical or health services provided by an eligible Provider who is not at the Member's location using an interactive, two-way telecommunications system (like real-time audio and visual). For most services, the Member will pay the same amount that would apply if the services were provided in-person.

Vision Care		
Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits in full for Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration, **except:** • The Part B Deductible; • The Part B Coinsurance.	The following charges, minus a $15 Copayment for an office visit: • The Part B Deductible; • The Part B Coinsurance.	• A $15 Copayment for an office visit.
Medicare benefits in full for one glaucoma screening each year for people who are at high-risk of developing glaucoma.*	• Nothing.	• Nothing.
Medicare benefits in full for one diabetic retinopathy screening each year for people with diabetes.	• Nothing.	• Nothing.
Medicare benefits in full for one pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens.*	• Nothing.	• Nothing.

Tufts Medicare Complement Plan Covered Services
Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for Medicare-approved vision care services. Additional vision care services may be provided (outside of Part B) under this plan. For more information, see the Additional Covered Services Provided by the Plan section of Chapter 3. ***Notes:** • People at high-risk for developing glaucoma include: people with a family history of glaucoma, people with diabetes, African Americans who are aged 50 and older, and Hispanic Americans who are 65 or older. • If a Member has two separate cataract operations, the Member cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery. There is an annual $150 allowance for eyeglasses and contacts.

Women's Health and Cancer Rights Act Coverage

Medicare Pays	**The Plan Pays**	**You Pay**
Medicare benefits on an Inpatient basis as described under Hospital Medical and Surgical Care – Inpatient.	As described under Hospital Medical and Surgical Care – Inpatient.	As described under Hospital Medical and Surgical Care – Inpatient.
Medicare benefits on an Outpatient basis as described under Hospital Medical and Surgical Care – Outpatient.	As described under Hospital Medical and Surgical Care – Outpatient.	As described under Hospital Medical and Surgical Care – Outpatient.

Tufts Medicare Complement Plan Covered Services
The Plan provides coverage up to the Allowed Charge for breast reconstruction in connection with a mastectomy. This includes the following services: • reconstruction of the breast affected by the mastectomy; • surgery and reconstruction of the other breast to produce a symmetrical appearance; and • prostheses and treatment of physical complications of all stages of mastectomy (including lymphedema).

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

Medicare Pays nothing for the following Covered Services provided by the Plan:	**The Plan Pays**	**You Pay**
• Routine physical exam: covered for one exam per calendar year.	All charges.	Nothing.
• Routine hearing exam: covered for one exam per calendar year.	All charges for one annual exam, minus a $15 Copayment for the exam.	A $15 Copayment for the exam.
• Routine eye exam (including refraction): covered for one exam every 24 months.	All charges for one exam every 24 months, minus a $15 Copayment for the exam.	A $15 Copayment for the exam.
• Fitness Reimbursement.	All combined charges up to a maximum benefit of $150 per calendar year.	All costs, after the maximum benefit of up to $150 per calendar year is reached.
• Lead screenings for Children, in accordance with Massachusetts law.	All charges.	Nothing.
• Hearing aids for Members aged 22 and over: Covered up to a maximum benefit of $1,700 in each 24-month period for both ears (combined). **Note:** This $1,700 maximum is reached as follows in the 24-month period: • The Plan pays the first $500. • Then, the Plan pays 80% of the next $1,500 towards the cost of the hearing aid.	The first $500 of a covered hearing aid, and then 80% of the next $1,500. Coverage is provided up to a maximum benefit of $1,700 in each 24-month period for both ears (combined).	After the first $500 paid by the Plan, 20% of the next $1,500 for a covered hearing aid. You also pay any balance over that $1,500. You also pay all costs, after the maximum benefit of $1,700 in each 24-month period is reached.

Additional Covered Services Provided by the Plan (for benefits not covered under Parts A and B of Medicare)		
Medicare Pays nothing for the following Covered Services provided by the Plan:	**The Plan Pays**	**You Pay**
• Hearing aids for Members aged 21 and under, in accordance with Massachusetts law.	All charges for each covered hearing aid. Coverage is provided up to a maximum benefit of $2,000 per ear every 24 months.	All costs, after the maximum benefit of $2,000 per ear every 24 months.
• Coronary Artery Disease Program A Coronary Artery Disease secondary prevention program assists Members with documented Coronary Artery Disease in making necessary lifestyle changes to reduce your cardiac risk factors. This benefit is available, when Medically Necessary, at designated programs to Members who meet the clinical criteria established for this program. For more information about this program, Members should call Member Services at 800-870-9488.	90% of charges for all Covered Services.	10% of charges for all Covered Services.
• Scalp hair prostheses worn for hair loss suffered due to the treatment of any form of cancer or leukemia.	All charges up to a maximum benefit of $350 per calendar year.	All costs, after the maximum benefit of up to $350 per calendar year is reached.
• Cleft lip or cleft palate treatment and services for children, in accordance with Massachusetts law.	All charges, minus the following charges for oral surgery covered under this benefit: • A $15 Copayment per office visit. • A $50 Copayment per Emergency Room visit. The Plan pays all charges for covered Inpatient and Day Surgery services.	The following charges for oral surgery covered under this benefit: • A $15 Copayment per office visit. • A $50 Copayment per Emergency Room visit. Nothing for covered Inpatient and Day Surgery services.

Medicare Pays nothing for the following Covered Services provided by the Plan:	**The Plan Pays**	**You Pay**
• Outpatient substance abuse services for medication-assisted treatment, including methadone maintenance.	All charges.	Nothing.
• Medically Necessary diagnosis and antibiotic treatment of chronic Lyme disease. • Long-term antibiotic treatment of chronic Lyme disease. Treatments for Lyme disease otherwise eligible for coverage under this benefit will not be denied solely because such treatment may be characterized as unproven, Experimental, or Investigative. **Note:** Long-term antibiotic treatment of chronic Lyme disease covered through your Prescription Drug Benefit are provided under the separate Medicare Plan D Plan administered by CVS SilverScript®. For more information, call 877-876-7214 or visit **www.gic.silverscript.com**.	All charges, minus a $15 Copayment per visit.	A $15 Copayment, depending on services received.
• Telemedicine Services		
• Office visit	All Covered Services, minus a $15 Copayment per visit.	A $15 Copayment per visit.
• Remote Patient Monitoring	All charges.	Nothing.
• Remote medical data transfer/ evaluation	All charges.	Nothing.
• Intensive community-based acute treatment (ICBAT)	All charges.	Nothing.
• Community-based acute treatment (CBAT)	All charges.	Nothing.
• Emergency Services Programs	All charges.	Nothing.
• Mental health wellness examination **Note:** Annual mental health wellness examinations can be performed by a mental health/substance abuse disorder Provider or by a medical Provider during a routine physical examination. A mental health wellness examination is a screening or assessment that seeks to identify any mental health needs and appropriate resources for treatment.	All charges.	Nothing.

Tufts Medicare Complement Plan – Additional Benefits and Reimbursements

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

Eyeglasses or contact lenses:
Members can receive 35% off the retail price of frames, and discounted lenses and lens options, with the purchase of a complete pair of eyeglasses or prescription sunglasses from a participating EyeMed Vision Care Provider. EyeMed also offers Members a contact lens replacement program; 20% off the retail price of nonprescription sunglasses; and 15% off the retail price (or 5% off the promotional price) of LASIK and PRK laser vision correction.

Note: Please see Vision Care on page 44 for information regarding the separate coverage under Medicare Part B for eyeglasses and contact lenses following cataract surgery.

Cleft lip or cleft palate treatment and services for Children:
In accordance with applicable law, the following services are covered for Children under the age of 18 when services are prescribed by the treating Physician/surgeon, and that Provider certifies that the services are Medically Necessary and required because of the cleft lip or cleft palate.

- Medical and facial surgery: This includes surgical management and follow-up care by plastic surgeons;
- Oral surgery: This includes surgical management and follow-up care by oral surgeons;
- Dental surgery or orthodontic treatment and management;
- Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management therapy;
- Speech therapy and audiology services; and
- Nutrition services.

Hearing aids for Members aged 21 and under:
In accordance with applicable law, the following services are covered for Members aged 21 and under upon written statement from that Member's treating Physician that the hearing aids are necessary regardless of the cause:

- One hearing aid per hearing impaired ear per prescription change up to $2,000 every 24 months;
- Hearing aid evaluations;
- Fitting and adjustment of hearing aids; and
- Supplies, including ear molds.

Hearing aids for Members aged 22 and over:
The following services are covered for Members aged 22 and over upon written statement from that Member's treating Physician that the hearing aids are necessary regardless of the cause:

- One hearing aid per hearing impaired ear per prescription change up to a maximum benefit of $1,700 every 24 months for both ears (combined);
- Hearing aid evaluations;
- Fitting and adjustment of hearing aids; and
- Supplies, including ear molds.

Tufts Medicare Complement Plan – Additional Benefits and Reimbursements

Fitness Reimbursement:
Covers up to a total of $150 per calendar year towards membership fees and/or exercise classes for a Member enrolled in a qualified health club or fitness facility. Important notes about this benefit:

- A qualified health club or fitness facility provides cardiovascular and strength training exercise equipment on site. Examples include traditional health clubs, YMCAs, YWCAs, and community fitness centers.
- This benefit does not cover fees paid to non-qualified health clubs or fitness facilities, including but not limited to, martial arts centers; gymnastics facilities; country clubs; social clubs; and facilities providing only yoga, Pilates, aerobics, golf, tennis, swimming, or other sports activity.
- To qualify for the fitness club rebate, you must complete four consecutive months of membership in Tufts Health Plan and at a qualified fitness center each year you apply. You will have 24 months from the date you incurred your fitness club fees to submit your request for the fitness rebate of up to $150. To submit your request, call Member Services to request a claim form or go to our website at **www.tuftshealthplan.com/gic**. The rebate applies one time per family, one time per year. The rebate is paid to the Tufts Health Plan Subscriber, regardless of which member submitted for reimbursement, after the fitness center fees are paid. Reimbursements are typically processed within 4 to 6 weeks of receipt.

For more information about this benefit, call Member Services.

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

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

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

Tufts Medicare Complement Plan – Additional Benefits and Reimbursements

Intensive community-based acute treatment:
Intensive community-based acute treatment (ICBAT) is an Inpatient mental health service available to children and adolescents until age 19. ICBAT provides the same services as CBAT (see below) for children and adolescents, but of higher intensity, including:

- more frequent psychiatric and psychopharmacological evaluation and treatment; and
- more intensive staffing and service delivery.

ICBAT programs have the capability to admit children and adolescents with more acute symptoms than those admitted to CBAT. ICBAT programs are able to treat children and adolescents with clinical presentations similar to those referred to Inpatient mental health services, but who are able to be cared for safely in an unlocked setting. Children and adolescents may be admitted to an ICBAT directly from the community as an alternative to Inpatient hospitalization. ICBAT is not used as a step-down placement following discharge from a locked, 24-hour hospital setting.

Community-based acute treatment:
Community-based acute treatment (CBAT) is an intermediate mental health service available to children and adolescents until age 19. CBAT services are provided in a staff-secure setting on a 24-hour basis, with sufficient clinical staffing to ensure safety for the child or adolescent, while providing intensive therapeutic services including, but not limited to:

- daily medication monitoring;
- psychiatric assessment;
- nursing availability;
- specialing (as needed);
- individual, group, and family therapy;
- case management;
- family assessment and consultation;
- discharge planning; and
- psychological testing, as needed.

These services may be used as an alternative to or transition from Inpatient services.

Emergency Services Programs:
Emergency Services Programs are covered as intermediate mental health and substance abuse disorder services under Massachusetts law. Emergency Services Programs provide community-based Emergency psychiatric services, including, but not limited to: mental health crisis assessment, intervention, and stabilization services. These services are available 24 hours per day, 7 days per week and can be received through adult community crisis stabilization services and Emergency Service Provider community-based locations.

Limitations on Benefits

Dental Care Services

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

Exclusions from Benefits

The Plan will not pay for the following services, supplies, or medications:

- A service, supply, or medication which is not Medically Necessary.
- A service, supply, or medication which is not a Covered Service.
- A service, supply, or medication that is not essential to treat an injury, illness, or pregnancy, except for preventive care services.
- A service, supply, or medication if there is a less intensive level of service supply, or medication or more cost-effective alternative which can be safely and effectively provided, or if the service, supply, or medication can be safely and effectively provided to you in a less intensive setting.
- A service, supply, or medication that is primarily for your, or another person's, personal comfort or convenience.
- Custodial Care.
- Services related to non-Covered Services.
- A drug, device, medical treatment, or procedure (collectively "treatment") that is Experimental or Investigative.
    - This exclusion does not apply to the following services, as per Massachusetts law:
        - long-term antibiotic treatment of chronic Lyme disease when administered as described under Medically Necessary diagnosis and antibiotic treatment of chronic Lyme disease earlier in this Chapter 3 (for drugs administered under a separate Medicare Part D Prescription Drug Plan administered by CVS SilverScript®);
        - bone marrow transplants for breast cancer; or
        - patient care services provided pursuant to a qualified clinical trial.
    - If the treatment is Experimental or Investigative, we will not pay for any related treatments which are provided to the Member for the purpose of furnishing the Experimental or Investigative treatment.
- Drugs, medicines, materials, or supplies for use outside the Hospital or any other facility, except as described earlier in this chapter. Coverage for prescription drugs is provided under the separate Medicare Part D Prescription Drug Plan administered by CVS SilverScript®.
- Injectable medications, except as described earlier in this chapter and for Intravenous Immunoglobulin (IVIg) therapy provided for the treatment of Pediatric Autoimmune Neuropsychiatric Disorders and Pediatric Acute-Onset Neuropsychiatric Syndromes, as required under Massachusetts law.
- Laboratory tests ordered by a Member (online or through the mail), even if performed in a licensed laboratory.

- The following exclusions apply to services provided by the relative of a Member:
  - Services provided by a relative who is not a Provider are not covered.
  - Services provided by an immediate family member (by blood or marriage), even if the relative is a Provider, are not covered.
  - If you are a Provider, you cannot provide or authorize services for yourself or a member of your immediate family (by blood or marriage).
- Services, supplies, or medications required by a third party which are not otherwise Medically Necessary. Examples of a third party are: employer; insurance company; school; or court.
- Services for which you are not legally obligated to pay or services for which no charge would be made if you had no health Plan.
- Care for conditions for which benefits are available under workers' compensation or other government programs other than Medicaid.
- Care for conditions that state or local law requires to be treated in a public facility.
- Charges or claims incurred as a result, in whole or in part, of fraud or misrepresentation (e.g., claims for services not actually rendered and/or able to be validated).
- Facility charges or related services if the procedure being performed is not a Covered Service.
- Cosmetic (meaning to change or improve appearance) surgery, procedures, supplies, medications, or appliances, except as described earlier in this chapter.

  Note: Breast reconstruction is covered when following a Medically Necessary mastectomy, as described in Women's Health and Cancer Rights Act Coverage on page 45.
- Human organ transplants, except as described earlier in this chapter.
- The Plan does not cover the cost of services (including tuition-based programs) that offer educational, vocational, recreational, or personal development activities, including, but not limited to: therapeutic schools, camps, wilderness or ranch programs, sports or performance enhancement programs, spas/resorts, leadership or behavioral coaching, or Outward Bound. The Plan will provide coverage for Medically Necessary Outpatient or intermediate behavioral health services provided by licensed behavioral health Providers while the Member is in a tuition-based program, subject to Plan rules, including any network requirements or Cost-Sharing.
- Multi-purpose general electronic devices, including, but not limited to, laptop computers, desktop computers, personal assistive devices (PDAs), tablets, and smartphones. All accessories for multi-purpose general electronic devices, including USB devices and direct connect devices (e.g., speakers, microphones, cables, cameras, batteries). Internet and modem connection/access including, but not limited to Wi-Fi®, Bluetooth®, Ethernet, and all related accessories.
- Hearing aids, except as described in Chapter 3.
- Routine foot care, such as: trimming of corns and calluses; treatment of flat feet or partial dislocations in the feet; orthopedic shoes and related items that are not part of a brace; foot orthotics or fittings; or casting and other services related to foot orthotics or other support devices for the feet, except:
  - This exclusion does not apply to therapeutic/molded shoes and shoe inserts for a Member with severe diabetic foot disease when the need for therapeutic shoes and inserts has been certified by the Member's treating doctor, and the shoes and inserts:
    - are prescribed by a Provider who is a podiatrist or other qualified doctor; and
    - are furnished by a Provider who is a podiatrist, orthotist, prosthetist, or pedorthist.
  - This exclusion also does not apply to routine foot care for Members diagnosed with diabetes.

- All Non-Conventional Medicine services, provided independently or together with conventional medicines, and all related testing, laboratory testing, services, supplies, procedures, and supplements associated with this type of medicine.
- Infertility services, infertility medications, and associated reproductive technologies (such as IVF, GIFT, and ZIFT) including, but not limited to:
  - Experimental infertility procedures.
  - The costs of surrogacy, including: (1) all costs (including, but not limited to, costs for drugs necessary to achieve implantation, embryo transfer, and cryo-preservation of embryos) incurred by a fertile woman to achieve a pregnancy as a surrogate or gestational carrier for an infertile Member; (2) use of donor egg and a gestational carrier; and (3) costs for maternity care if the surrogate is not a Member.
    - A surrogate is a person who carries and delivers a child for another either through artificial insemination or surgical implantation of an embryo.
    - A gestational carrier is a surrogate with no biological connection to the embryo/child.
- Reversal of voluntary sterilization.
- Sperm or embryo cryopreservation.
- Donor recruitment fee for donor egg or donor sperm.
- Donor sperm and associated laboratory services.
- Costs associated with donor recruitment and compensation.
- Infertility services that are necessary for conception as a result of voluntary sterilization or after an unsuccessful reversal of a voluntary sterilization.
- Preimplantation genetic testing and related procedures performed on gametes or embryos.
- Treatments, medications, procedures, services, and supplies related to reversal of voluntary sterilization.
- Service or therapy animals and related supplies.

Chapter 4: When Coverage Ends

Overview

This chapter tells you when coverage ends.

Reasons Coverage Ends

Coverage ends when any of the following occurs:

- You lose eligibility because you no longer meet the GIC's eligibility rules.
- You lose eligibility because:
  - you no longer are enrolled in Medicare Parts A and B;
  - you choose to drop coverage; or
  - material misrepresentation.

When a Member is No Longer Eligible

Loss of Eligibility

Your coverage ends on the date you no longer meet the GIC's eligibility rules or no longer are enrolled in Medicare Parts A and B.

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

You Choose to Drop Coverage

You may cancel your coverage within 60 days of a qualifying event or during the GIC's Annual Enrollment Period. Enrollment and change forms are available on the GIC's website at **https://mygiclink.force.com/GenerateDocusignPage**, or you may contact the Group Insurance Commission at 617-727-2310 or visit **http://www.mass.gov/gic** for more information.

Membership Termination for Material Misrepresentation

Policy

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

Acts of Material Misrepresentation

Examples of material misrepresentation include:

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

Date of Termination

If the Plan terminates your coverage for material misrepresentation, your coverage will end as of your Effective Date or a later date chosen by the Plan.

Payment of Claims

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

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

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

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

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

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

Termination of the Group Contract

End of Tufts Health Plan's and the GIC's Relationship

Coverage will terminate if the relationship between the Group Insurance Commission and Tufts Health Plan ends for any reason, including:

- the GIC's contract with us terminates;
- the GIC fails to pay contributions for Member coverage on time;
- we no longer offer this Tufts Medicare Complement Plan to the GIC; or
- we stop operating.

Important Notes about Appeals and Grievances

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

Tufts Health Plan Member Appeals Process

Tufts Health Plan ("Tufts HP") has a Member Satisfaction Process to address your concerns promptly about a service under this Plan only (and **not** under Medicare). This process addresses:

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

All calls should be directed to the Member Services Department at 800-870-9488**.** To submit your appeal or grievance in writing, send your letter to the address below. Or, you may fax it to us at 617-972-9509.

Tufts Health Plan
Attn: Appeals and Grievances Department
P.O. Box 9193
Watertown, MA 02472-9193

You may also submit your appeal or grievance at this address:

Tufts Health Plan
1 Wellness Way
Canton, MA 02021

Internal Inquiry

Call the Member Services Department at 800-870-9488 to discuss concerns you may have regarding your health care. Every effort will be made to resolve your concerns. If your concerns cannot be explained or resolved, or if you tell a Member Services Representative that you are not satisfied with the response you have received from Tufts HP, we will notify you of any options you may have, including the right to have your inquiry processed as a grievance or appeal. If you choose to file a grievance or appeal, you will receive written acknowledgement and written resolution in accordance with the timelines outlined below.

Grievances

A grievance is a formal complaint about actions taken by Tufts HP or a Provider. There are two types of grievances: administrative grievances and clinical grievances. The two types of grievances are described below.

It is important that you contact Tufts HP as soon as possible to explain your concern. Grievances may be filed either verbally or in writing. If you choose to file a grievance verbally, please call a Tufts HP Member Services Representative, who will document your concern and forward it to an Appeals and Grievances Specialist in the Appeals and Grievances Department. To accurately reflect your concerns, you may want to put your grievance in writing and send it to the P.O. Box address provided at the beginning of this section. Your explanation should include:

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

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

Administrative Grievance

An administrative grievance is a complaint about a Tufts HP employee, department, policy, or procedure, or about a billing issue.

Administrative Grievance Timeline

- If you file your grievance verbally or in writing, Tufts HP will notify you by mail, within five (5) business days after receiving your grievance, that your grievance has been received and provide you with the name, address, and telephone number of the Appeals and Grievances Specialist coordinating the review of your grievance.
- Tufts HP will review your grievance and will send you a letter regarding the outcome within thirty (30) calendar days of receipt.
- The time limits in this process may be waived or extended upon mutual written agreement between you or your authorized representative and Tufts HP.

Clinical Grievances

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

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

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

Internal Member Appeals

Requests for coverage that were denied as specifically excluded in this Member Handbook (or subsequent updates) or for coverage that was denied based on Medical Necessity determinations are reviewed as appeals through Tufts Health Plan's Internal Appeals Process. You may file a request yourself or you may designate someone to act on your behalf in writing. You have 180 days from the date you were notified of the denial of benefit coverage or claim payment to file your appeal.

(i) You can submit a verbal appeal of a benefit coverage decision to the Member Services Department, who will forward it to the Appeals and Grievances Department. You can also submit a written appeal to the P.O. Box address listed above under Grievances. Tufts HP encourages you to submit your appeal in writing to accurately reflect your concerns. Your letter should include:

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

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

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

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

(iv) The Appeals and Grievances Specialist will notify you in writing of the Committee's decision within no more than 30 calendar days of the receipt of your appeal. The time limits may be waived or extended beyond the time allowed by law upon mutual verbal or written agreement between you or your authorized representative and Tufts Health Plan. A copy of the decision will be sent to your Physician, unless you request otherwise. A determination of claim denial will set forth:

- Tufts Health Plan's understanding of the request;
- The reason(s) for the denial;
- The specific contract provisions on which the denial is based;
- The clinical rationale for the denial, if the appeal involves a Medical Necessity determination.

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

Expedited (Fast) Appeals

Tufts HP recognizes that there are urgent circumstances that require a quicker turnaround than the thirty (30) calendar days allotted for the standard Appeals Process. Tufts HP will expedite an appeal when your health may be in serious jeopardy or, in the opinion of your treating Provider (the practitioner responsible for the treatment or proposed treatment), you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal.

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

Your review will generally be conducted within two (2) business days, but not later than 72 hours (whichever is less) after Tufts HP's receipt of the request. If your appeal meets the guidelines for an expedited appeal, you may also file a request for a simultaneous external review as described below.

External Review

For appeals involving Medical Necessity determinations (adverse determinations) and benefit reviews where medical judgement was used, you or your authorized representative have the right to request an independent, external review of our Appeals decision (appeals for payment disputes and coverage of services specifically excluded in your Member Handbook are not eligible for external review).

Should you choose to request an external review, send your request within four months of your receipt of written notice of the denial of your appeal to:

Tufts Health Plan
Medicare Complement Plan
Attn: Appeals & Grievances Department
1 Wellness Way
Canton, MA 02021
Fax: 617-972-9509

In some cases, Members may have the right to an expedited (fast) external review. An expedited external review may be appropriate in urgent situations. An urgent situation is one in which your health may be in serious jeopardy, or, in the opinion of your Physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. Additionally, if Tufts Health Plan has not met all of our major procedural requirements (as listed above under internal appeals) for matters subject to external review, you can immediately file an external appeal.

If you request an external review, an independent organization will review the decision and provide you with a written determination. If this organization decides to overturn the appeal decision, the service or supply will be covered under the Plan.

If You Have Questions
If you have questions or need help submitting a grievance or an appeal, please call the Member Services Department at 800-870-9488 for assistance.

Limitation on Actions

You cannot file a lawsuit against Tufts Health Plan for failing to pay or arrange for Covered Services unless you have completed our Member Satisfaction Process and file the lawsuit within two years from the time the cause of action arose. For example, if you want to file a lawsuit because you were denied coverage under this Member Handbook, you must first complete our Member Satisfaction Process, and then file your lawsuit within the next two years after the date you were first sent a notice of the denial. Going through the Member Satisfaction Process does not extend the time limit for filing a lawsuit beyond the two years after the date you were first denied coverage.

Subrogation and Right of Recovery

The provisions of this section apply to all current and former Plan participants. This Plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representatives or administrators of your estate, your decedents, your heirs, your descendants, your beneficiaries, minors, and incompetent or disabled persons. These provisions will apply to all claims arising from your illness or injury, including, but not limited to, wrongful death, survival, or survivorship claims brought on your, your estate's, or your heirs' behalf, regardless of whether medical expenses were or could be claimed. "You" and "your" includes anyone on whose behalf the Plan pays benefits. No Member hereunder may assign any rights that it may have to recover medical expenses from any person or entity responsible for causing your injury, illness, or condition without the prior express written consent of the Plan.

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

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

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

Subrogation

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

Reimbursement

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

Constructive Trust

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

Lien Rights

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

Subrogation Agent

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

Assignment

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

First-Priority Claim

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

Applicability to All Settlements and Judgments

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

Cooperation

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

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

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

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

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

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits from the Plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the Plan incurs in successful attempts to recover amounts the Plan is entitled to under this section.

Workers' Compensation

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

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

If the Plan pays for the costs of health care services or medications for any work-related illness or injury, the Plan has the right to recover those costs from you, the person, or company legally obligated to pay for such services, or from the Provider. If your Provider bills services or medications to the Plan for any work-related illness or injury, please contact the Tufts Health Plan Liability to Recovery Department at 1-888-880-8699, x. 21098.

Future Benefits

Benefits for otherwise covered services may be excluded when you have received a recovery from another source relating to an illness or injury for which benefits would normally be provided. However, the amount of any Covered Services excluded under this section will not exceed the amount of your recovery.

Coordination of Benefits

Benefits under Other Plans

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

The Plan has a coordination of benefits program (COB) that prevents duplication of payment for the same health care services. We will coordinate benefits payable for Covered Services with benefits payable by other Plans, consistent with state law.

Primary and Secondary Plans

The Plan will coordinate benefits by determining:

- which Plan has to pay first when you make a claim; and
- which Plan has to pay second.

We will make these determinations according to applicable state law.

Right to Receive and Release Necessary Information

When you enroll, you must include information on your membership application about other health coverage you have.

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

You agree to provide information about other coverage and cooperate with the Plan's COB program.

Right to recover overpayment

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

For more information

For more information about COB, call Member Services: 800-870-9488.

Coverage for Pre-existing Conditions

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

Circumstances Beyond Tufts Health Plan's Reasonable Control

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

Group Contract

Acceptance of the Terms of the Group Contract

By signing and returning the membership application form, you apply for Group coverage and agree to all the terms and conditions of the Group Contract, including this Member Handbook.

Payments for Coverage

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

Changes to This Member Handbook

The GIC may change this Plan and this Member Handbook in accordance with the terms of the Plan. Revisions do not require the consent of Members. Notice of Tufts Health Plan's revisions will be sent to the GIC and will include the Effective Date of the revision. The GIC is responsible for notifying the Members of revisions. We are not responsible if the GIC does not so notify Members. Any revisions will apply to all Members covered under the Plan on the Effective Date of the revision.

Notice

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

Notice to us: Members should address all correspondence to:

Tufts Health Plan
P.O. Box 9193
Watertown, MA 02472-9193.

Enforcement of Terms

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

When this Member Handbook is Issued and Effective

This Member Handbook is issued and effective the Anniversary Date on or after July 1, 2022, and supersedes all previous Member Handbook.

Appendix A: Glossary of Terms

Terms and Definitions

This section defines the terms used in this Member Handbook.

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

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

- any workers' compensation, employer's liability, or similar law;
- motor vehicle no-fault Plan;
- or other motor vehicle insurance-related Plan, unless prohibited by law.

Allowed Charge
An Allowed Charge is the expense used to determine payment of Plan benefits listed in this Member Handbook.

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

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

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

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

Benefit Period

- A Benefit Period begins the day you receive covered Inpatient Services in a Hospital or Skilled Nursing Facility.
- The Benefit Period ends when you have not received covered Inpatient Services in a Hospital or Skilled Nursing care for 60 days in a row.
- If you go into the Hospital after one Benefit Period has ended, a new Benefit Period begins.
- You must pay the Inpatient Hospital Deductible for each Benefit Period.

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

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

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

Covered Services
The services and supplies for which the Plan will pay under this Member Handbook must be:

- described in Chapter 3;
- for Medicare-approved services, obtained by a Provider who accepts assignment from Medicare; and
- except for preventive care, Medically Necessary.

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

Custodial Care

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

Note: Custodial Care is not covered by the Plan.

Deductible
The amount you must pay for health care before Medicare begins to pay for Medicare Covered Services. There is a Deductible for each Benefit Period for Part A and each year for Part B. These amounts can change every year.

Appendix A: Glossary of Terms, *(continued)*

Durable Medical Equipment
Devices or instruments of a durable nature that:

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

Effective Date
This is the date which according to the Plan's records you become a Member and are first eligible for Covered Services.

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

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

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

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

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

Group Insurance Commission (GIC)
The Massachusetts state agency that provides health insurance for state and Participating Municipality retired employees and their eligible Dependents.

Group Contract
The agreement between Tufts Health Plan and the Group Insurance Commission under which we agree to provide certain administrative services and the GIC agrees to pay us for these services. The Group Contract includes this Member Handbook and any documents.

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

Individual Coverage
Coverage for a Member only.

Inpatient
A patient who is:

- admitted to a Hospital or other facility licensed to provide continuous care; and
- classified as an Inpatient for all or a part of the day.

Medically Necessary

- **For a service eligible for coverage under Medicare:** This means "Medically Necessary" as determined by Medicare. See your Medicare Handbook or contact Medicare for more information.
- **For a service that qualifies as a Covered Service under this Tufts Medicare Complement Plan Member Handbook only:** This term has the following meaning:
  - A service or supply that is consistent with generally accepted principles of professional medical practice as determined by whether that service or supply;
  - Is the most appropriate available supply or level of services for the Member in question considering potential benefits and harms to that individual;
  - Is known to be effective, based on scientific evidence, professional standards, and expert opinion, in improving health outcomes; or
  - for services and interventions not in widespread use, is based on scientific evidence.

In determining coverage for Medically Necessary Services, Tufts Health Plan uses Medical Necessity Guidelines which are:

- based on current literature review;
- developed with input from practicing Providers;
- developed in accordance with the standards adopted by government agencies and national accreditation organizations;
- updated annually or more often as new treatments, applications, and technologies are adopted as generally accepted professional medical practice; and
- scientific evidence-based, if practicable.

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

Medicare-approved Amount
The Amount a Physician or supplier that accepts assignment can be paid by Medicare.

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

Medicare Eligible Expenses
Expenses of the kind covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

Member
A person who is covered under the Plan and therefore entitled to all benefits in accordance with the Plan. Also referred to as "you".

Member Handbook
This document, and any future amendments, which describes the Plan in which you have enrolled. This Member Handbook is the agreement for the coverage under the Plan between the Group Insurance Commission and Tufts Health Plan.

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

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

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

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

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

- a Physician's office;
- an Ambulatory Surgical Center; and
- an Emergency Room or Outpatient clinic.

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

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

- medicine; or
- osteopathy.

Participating Municipality
A city, town, or district of the Commonwealth of Massachusetts that participates in the health coverage offered by the Group Insurance Commission.

Plan
Tufts Medicare Complement Plan, the Group Insurance Commission's self-funded Plan administered by Tufts Health Plan, which provides you with the benefits described in this Member Handbook.

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

The types of Providers covered under the Plan include, but are not limited to: Ambulatory Surgical centers; Hospitals; Physicians; Physician assistants; certified nurse midwives; certified registered nurse anesthetists; nurse practitioners; optometrists; podiatrists; psychologists; licensed mental health counselors; licensed independent clinical social workers; licensed drug and alcohol counselor I; and Skilled Nursing Facilities.

The Plan will only cover services of a Provider, if those services are:

- listed as Covered Services; and
- within the scope of the Provider's license.

Important Note – Providers outside of Massachusetts:
No coverage is available under this Plan for services obtained by the following types of Providers **outside of Massachusetts**:

- clinical specialists in psychiatric and mental health nursing;
- licensed independent clinical social workers (for Covered Services under this Plan only);
- licensed mental health counselors; and
- psychologists (for Covered Services under this Plan only).

Reserve days
Sixty days that Medicare will pay for when you are put in a Hospital for more than 90 days of Medicare Covered Services. These 60 Reserve days can be used only once during your lifetime. For each lifetime Reserve day, Medicare pays all covered costs except for a daily Coinsurance amount.

Appendix A: Glossary of Terms, *(continued)*

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

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

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

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

Tufts Health Plan or Tufts HP
Tufts Benefit Administrators, Inc., a Massachusetts corporation d/b/a Tufts Health Plan. Tufts HP does not insure this Tufts Medicare Complement Plan offered by the GIC. Also referred to as "we," "us," or "our."

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

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

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

SilverScript®

P.O. Box 30006, Pittsburgh, PA 15222-0330

Commonwealth of Massachusetts
Group Insurance Commission

PART II:

PRESCRIPTION DRUG PLAN

2022 Summary of Benefits

SilverScript Employer PDP sponsored by the Group Insurance Commission (SilverScript)

A Medicare Prescription Drug Plan (PDP) offered by SilverScript® Insurance Company with a Medicare contract

January 1, 2022 – December 31, 2022

PART II – PRESCRIPTION DRUG PLAN

About SilverScript

SilverScript Employer PDP sponsored by the *Group Insurance Commission* (GIC) is a Medicare-approved Part D prescription drug plan with additional coverage provided by the GIC to expand the Part D benefits. "Employer PDP" means that the plan is an employer-provided prescription drug plan. The plan is offered by SilverScript® Insurance Company, which is affiliated with CVS Caremark®, the GIC's pharmacy benefit manager.

You are automatically enrolled in SilverScript coverage when you enroll in one of GIC's Medicare products. Do not enroll in any other Part D (prescription drug) plan. Doing so will immediately terminate your GIC health and prescription drug coverage.

Plan Costs

This section includes information about your monthly premium, annual deductible (if any), and cost-sharing amounts during the Initial Coverage Stage for SilverScript. Although most members do not reach the Coverage Gap Stage (Stage 3) or the Catastrophic Coverage Stage (Stage 4) during the plan year, a summary of your costs in those stages is also included.

Monthly Premium

There is no separate prescription drug premium. This benefit is provided as part of your GIC health plan coverage.

Please note: If your modified adjusted gross income is above a certain amount, you may pay a Part D income-related monthly adjustment amount (Part D IRMAA). Medicare uses the modified adjusted gross income reported on your IRS tax return from 2 years ago (the most recent tax return information provided to Social Security by the IRS).

If Social Security notifies you about paying a higher amount for your Part D coverage, you're required by law to pay the Part D-Income Related Monthly Adjustment Amount (Part D IRMAA). **You pay your Part D IRMAA directly to Medicare, not to your plan or employer.**

You're required to pay the Part D IRMAA, even if your employer or a third party (like a teacher's union or a retirement system) pays for your Part D plan premiums. If you don't pay the Part D IRMAA and get disenrolled, you may also lose your retirement coverage and you may not be able to get it back.

For more information about Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227).

Medicare Part D Drug Payment Stages

All Medicare Part D prescription drug plans have drug payment stages where drug costs may vary. You move through each stage based on the amount either you or the plan spend on prescription drugs. See the following section for information on the Medicare Part D drug payment stages. The Part D Explanation of Benefits (EOB) and other plan materials include additional information on the four drug payment stages.

Stage 1: Deductible Stage

Because you have no deductible, this payment stage does not apply to you.

Stage 2: Initial Coverage Stage Cost Sharing

During the Initial Coverage Stage, you pay a portion of your drug costs, and the plan pays its portion. The following tables show what you pay until your total yearly drug costs reach $4,430. Total yearly drug costs are the total drug costs paid by both you and SilverScript. You may get your drugs at network retail pharmacies or through the mail-order pharmacy.

2022 SilverScript Summary of Prescription Drug Benefits for The *Group Insurance Commission*			
Monthly Premium	There is no separate prescription drug premium. This benefit is provided as part of your GIC health plan coverage.		
Deductible	This plan does not have a deductible.		
Your share of the cost when you get a 30-day supply of a covered Part D prescription drug:			
	Network Retail Pharmacy (Up to a 30-day supply available at **any** network pharmacy)	**Mail-Order Pharmacy** (Up to a 30-day supply)	**Long-Term Care (LTC) Pharmacy** (Up to a 31-day supply)
Tier 1: Generic	$10	$25	$10
Tier 2: Preferred Brand	$30	$75	$30
Tier 3: Non-Preferred Brand	$65	$165	$65
Your share of the cost when you get a long-term supply (up to 90 days) of a covered Part D prescription drug:			
	Preferred Network Retail Pharmacy (Up to a 90-day supply)	**Standard Network Retail Pharmacy** (Up to a 90-day supply)	**Mail-Order Pharmacy** (Up to a 90-day supply)
Tier 1: Generic	$25	$30	$25
Tier 2: Preferred Brand	$75	$90	$75
Tier 3: Non-Preferred Brand	$165	$195	$165

Note: You pay the same share of the cost for your drug filled through the Mail-Order Pharmacy, whether you get a one-month supply or a long-term supply. This means that the copayment or coinsurance listed in the previous table is applicable for any order, regardless of the day supply.

Please note, if you go to an out-of-network pharmacy, you will be reimbursed the cost of the drug less your cost share.

Stage 3: Coverage Gap Stage Cost Sharing

The coverage gap begins after the total yearly drug costs (including what the plan has paid and what you have paid) reaches $4,430.

Due to the additional coverage provided by The *Group Insurance Commission*, you have the same copayments or coinsurance that you had during the Initial Coverage Stage. Therefore, you may see no change in your copayment and/or coinsurance until you qualify for catastrophic coverage.

Your share of the cost when you get a 30-day supply of a covered Part D prescription drug:			
	Network Retail Pharmacy (Up to a 30-day supply available at **any** network pharmacy)	**Mail-Order Pharmacy** (Up to a 30-day supply)	**Long-Term Care (LTC) Pharmacy** (Up to a 31-day supply)
Tier 1: Generic	$10	$25	$10
Tier 2: Preferred Brand	$30	$75	$30
Tier 3: Non-Preferred Brand	$65	$165	$65
Your share of the cost when you get a long-term supply (up to 90 days) of a covered Part D prescription drug:			
	Preferred Network Retail Pharmacy (Up to a 90-day supply)	**Standard Network Retail Pharmacy** (Up to a 90-day supply)	**Mail-Order Pharmacy** (Up to a 90-day supply)
Tier 1: Generic	$25	$30	$25
Tier 2: Preferred Brand	$75	$90	$75
Tier 3: Non-Preferred Brand	$165	$195	$165

Stage 4: Catastrophic Coverage Stage Cost Sharing

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,050 you pay 5% of the cost for a covered drug but not greater than the cost share amounts listed in the Initial Coverage Stage section above.

Who can join?

To join SilverScript, you must be eligible for coverage provided by The *Group Insurance Commission*, be entitled to Medicare Part A and/or be enrolled in Medicare Part B, be a United States citizen or be lawfully present in the United States and live in our service area. SilverScript is available in the United States and its territories.

Which drugs are covered?

To find out if your drug is on the formulary (list of Part D prescription drugs) or about any restrictions, call Customer Care (phone numbers are printed on the back cover of this booklet). You may also request a copy of the complete plan formulary.

Please note: The *Group Insurance Commission* provides additional coverage that may cover prescription drugs not included in your Medicare Part D benefit, such as:

- Prescription drugs for anorexia, weight loss, or weight gain
- Prescription drugs for the symptomatic relief of cough or cold
- Prescription vitamins and mineral products not covered by Part D
- Prescription drugs for treatment of sexual or erectile dysfunction
- Certain diabetic drugs and supplies not covered by Part D
- Prescription drugs for tobacco cessation
- Part B products, such as oral chemotherapy agents

For more information about your share of the cost or which prescription drugs may or may not be covered, please call Customer Care (phone numbers are printed on the back cover of this booklet). The SilverScript formularies do not include any drugs that may be available to you through the additional coverage provided by The *Group Insurance Commission*.

How will I determine my drug costs?

SilverScript groups each medication into one of three tiers. Use your formulary to find out the tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and whether you are in the Deductible (if any), Initial Coverage, Coverage Gap, or Catastrophic Coverage Stage. As you move from stage to stage, the amount you and the plan pay for your drugs may change. If the actual cost of a drug is less than the normal copayment or coinsurance for that drug, you will pay the actual cost, not the higher copayment or coinsurance.

Which pharmacies can I use?

More than 66,000 pharmacies nationwide make up the pharmacy network. These include retail, mail-order, long-term care and home infusion pharmacies. To find a network pharmacy near your home or where you are traveling in the United States or its territories, call Customer Care (phone numbers are printed on the back cover of this booklet).

You generally must use a network pharmacy in order to receive full benefit coverage on your prescriptions. You may get drugs from an out-of-network pharmacy in an emergency, but you may have to pay the full cost (rather than your normal share of the cost) at the time you fill your prescription. If you use an out-of-network pharmacy, we will reimburse you your total cost minus your copay amount for the drug. You must submit a paper claim in order to be reimbursed.

If you need to get your prescription filled while you are traveling outside the country, contact Customer Care **before** you leave the U.S. You can request a vacation override for up to a 90-day supply of your medication. If you are traveling outside of the country and have an emergency drug expense, submit your itemized receipt with the completed SilverScript claim form to the GIC at P.O. Box 556, Randolph, MA 02368.

Please note: Veterans Affairs (VA) pharmacies are not permitted to be included in Medicare Part D pharmacy networks. The federal government does not allow you to receive benefits from more than one government program at the same time.

If you are eligible for VA benefits, you may still use VA pharmacies under your VA benefits. However, the cost of those medications and what you pay out-of-pocket will not count toward your Medicare out-of-pocket costs or Medicare total drug costs. Each time you get a prescription filled, you can compare your GIC benefit through SilverScript to your VA benefit to determine the best option for you.

Through the additional coverage provided by the GIC, you may be able to save on your maintenance prescription drugs by changing your 30-day supply to a 90-day supply at any CVS Pharmacy®, Longs Drugs (operated by CVS Pharmacy), or Navarro Discount Pharmacy location. These pharmacies are called "preferred network retail pharmacies."

If you're currently taking any long-term prescription drugs, you can continue to fill your 30-day supplies. However, you may save by changing your 30-day supply to a lower-cost 90-day supply. Filling one 90-day supply may cost you less than three 30-day supplies of the same prescription drug.

You can choose from two 90-day supply options for the same low price.

Option 1: Refill at any CVS Pharmacy, Longs Drugs (operated by CVS Pharmacy), or Navarro Discount Pharmacy location, and pick up your prescription drugs at your convenience.

Option 2: Refill with CVS Caremark Mail Service Pharmacy and have a 90-day supply of your long-term prescription drugs shipped to your home.

For questions about maintenance drugs with additional coverage provided by the GIC, including the cost to fill these drugs, please contact Customer Care (phone numbers are printed on the back cover of this booklet).

Please note: After the mail-order pharmacy receives an order, it typically takes up to 10 days for you to receive your prescription drug. You have the option to sign up for automated mail-order delivery.

This booklet provides a summary of what SilverScript covers and what you will pay. To get a complete list of our benefits, please call Customer Care (phone numbers are printed on the back cover of this booklet) and ask for the Evidence of Coverage.

If you want to know more about the coverage and costs of Original Medicare, look in your current Medicare & You handbook. View it online at **www.medicare.gov** or get 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.

The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

SilverScript's pharmacy network includes limited lower-cost, preferred pharmacies in Alaska; suburban and rural areas of Idaho, Puerto Rico, Washington, and Wyoming; and rural areas of Arkansas, Colorado, Iowa, Kansas, Kentucky, Maine, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Mexico, North Dakota, Oklahoma, Oregon, and Wisconsin. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call 1-877-876-7214 (TTY: 711), 24 hours a day, 7 days a week, or consult the online pharmacy directory at **https://gic.silverscript.com/**.

Members who get "Extra Help" are not required to fill prescriptions at preferred network pharmacies in order to get Low Income Subsidy (LIS) copays.

The typical number of business days after the mail-order pharmacy receives an order to receive your shipment is up to 10 days. Enrollees have the option to sign up for automated mail-order delivery.

SilverScript Employer PDP is a Prescription Drug Plan. This plan is offered by SilverScript Insurance Company, which has a Medicare contract. Enrollment depends on contract renewal.

IMPORTANT INFORMATION:

2022 Medicare Star Ratings

SILVERSCRIPT INSURANCE COMPANY (S5601)

Official U.S. Government Medicare Information

For 2022, SILVERSCRIPT INSURANCE COMPANY (S5601) received the following Star Ratings from Medicare:

Overall Star Rating: ★★★½☆

Health Services Rating: Not Offered

Drug Services Rating: ★★★½☆

**Some plans do not have enough data to rate performance.*

Every year, Medicare evaluates plans based on a 5-star rating system.

Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

More stars mean a better plan – for example, members may get better care and better, faster customer service.

The number of stars shows how well our plan performs.

★★★★★	EXCELLENT
★★★★☆	ABOVE AVERAGE
★★★☆☆	AVERAGE
★★☆☆☆	BELOW AVERAGE
★☆☆☆☆	POOR

Get More Information on Star Ratings Online

Compare Star Ratings for this and other plans online at **medicare.gov/plan-compare**.

Questions about this plan?

Contact SILVERSCRIPT INSURANCE COMPANY 7 days a week from October 1 – March 31, 7 a.m. to 11 p.m., CST, or 5 days a week (M-F) from April 1 – September 30, 7 a.m. to 11 p.m., CST, at 1-833-526-2445 (toll-free) or 711 (TTY).

Current members please call 24 Hours a day Local time, 7 days a week, 1-866-235-5660 (toll-free) or 711 (TTY).

SilverScript Employer PDP is a Prescription Drug Plan. This plan is offered by SilverScript Insurance Company, which has a Medicare contract. Enrollment depends on contract renewal.

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SilverScript®
P.O. Box 30006, Pittsburgh, PA 15222-0330

Commonwealth of Massachusetts
Group Insurance Commission

Important Plan Information
Información Importante Sobre el Plan

SilverScript Customer Care

CALL	1-877-876-7214 Calls to this number are free, 24 hours a day, 7 days a week. SilverScript Customer Care also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free, 24 hours a day, 7 days a week.
FAX	1-888-472-1129
WRITE	SilverScript Insurance Company P.O. Box 30016 Pittsburgh, PA 15222-0330

FOR SUBSCRIBERS ENROLLED IN TUFTS MEDICARE COMPLEMENT PLAN

P.O. Box 556, Randolph, MA 02368

Group Health Continuation Coverage Under COBRA

ELECTION NOTICE AND APPLICATION

This notice explains your COBRA rights and what you need to do to protect your right to receive it. You will receive a COBRA notice and application if the *Group Insurance Commission* (GIC) is informed that your current GIC coverage is ending due either to (1) end of employment; (2) reduction in hours of employment; (3) death of employee/retiree; (4) divorce or legal separation; or (5) loss of dependent child status. This COBRA notice contains important information about your right to temporarily continue your health care coverage in the *Group Insurance Commission's* (GIC's) health plan through a federal law known as COBRA. If you elect to continue your coverage, COBRA continuation coverage will begin on the first day of the month immediately after your current GIC coverage ends.

You must complete the GIC COBRA Election Form and return it to the GIC by no later than 60 days after your group coverage ends by sending it by mail to the Public Information Unit at the GIC at P.O. Box 556, Randolph, MA 02368 or by hand delivery to the GIC, 1 Ashburton Place, Suite 1619. If you do not submit a completed election form by this deadline, you will lose your right to elect COBRA coverage.

WHAT IS COBRA CONTINUATION COVERAGE?
COBRA is a federal law under which certain former employees, retirees, spouses, former spouses, and dependent children have the right to temporarily continue their existing group health coverage at group rates when group coverage otherwise would end due to certain life events, called 'Qualifying Events.' If you elect COBRA continuation coverage ("COBRA coverage"), you are entitled to the same coverage being provided under the GIC's plan to similarly situated employees or dependents. The GIC administers COBRA coverage.

This notice explains your COBRA rights and what you need to do to protect your right to receive it. If you have questions about COBRA coverage, contact the GIC's Public Information Unit at 617-727-2310 or write to the Unit at P.O. Box 556, Randolph, MA 02368. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration's website at **www.dol.gov/ebsa** for more general information about COBRA.

WHO IS ELIGIBLE FOR COBRA CONTINUATION COVERAGE?
Each individual entitled to COBRA (known as a "Qualified Beneficiary") has an *independent right* to elect the coverage, regardless of whether or not other eligible family members elect it. Qualified Beneficiaries may elect to continue their group coverage that otherwise would end due to the following life events:

If you are an employee of the Commonwealth of Massachusetts or municipality covered by the GIC's health benefits program, you have the right to choose COBRA coverage if:

- You lose your group health coverage because your hours of employment are reduced; or
- Your employment ends for reasons other than gross misconduct.

If you are the spouse of an employee covered by the GIC's health benefits program, you have the right to choose COBRA coverage for yourself if you lose GIC health coverage for any of the following reasons (known as "qualifying events"):

- Your spouse dies;
- Your spouse's employment with the Commonwealth or participating municipality ends for any reason other than gross misconduct;
- Your spouse's hours of employment with the Commonwealth or participating municipality are reduced; or
- You and your spouse legally separate or divorce.

If you have dependent children who are covered by the GIC's health benefits program, each child has the right to elect COBRA coverage if he or she loses GIC health coverage for any of the following reasons (known as "qualifying events"):

- The employee-parent dies;
- The employee-parent's employment is terminated (for reasons other than gross misconduct);
- The employee-parent's hours or employment are reduced;
- The parents legally separate or divorce; or
- The dependent ceases to be a dependent child under GIC eligibility rules.

HOW LONG DOES COBRA CONTINUATION COVERAGE LAST?
By law, COBRA coverage must begin on the day immediately after your group health coverage otherwise would end. If your group coverage ends due to employment termination or reduction in employment hours, COBRA coverage may last for up to 18 months. If it ends due to any other qualifying events listed above, you may maintain COBRA coverage for up to 36 months.

If you have COBRA continuation coverage due to employment termination or reduction in hours, your family members' COBRA continuation coverage may be extended beyond the initial 18-month period up to a *total* of 36 months (as measured from the initial qualifying event) if a second qualifying event – the insured's death or divorce – occurs during the 18 months of COBRA coverage. **You must notify the GIC in writing within 60 days of the second qualifying event and before the 18-month COBRA period ends in order to extend the coverage**. Your COBRA coverage may be extended to a total of 29 months (as measured from the initial qualifying event) if any qualified beneficiary in your family receiving COBRA coverage is disabled during the first 60 days of your 18-month COBRA coverage. **You must provide the GIC with a copy of the Social Security Administration's disability determination within 60 days after you receive it and before your initial 18-month COBRA period ends in order to extend the coverage**. For more information about extending the length of COBRA continuation coverage, visit **https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/an-employees-guide-to-health-benefits-under-cobra.pdf**.

COBRA continuation coverage will end before the maximum coverage period ends if any of the following occurs:

- The COBRA cost is not paid ***in full*** when due (see section on paying for COBRA);
- You or another qualified beneficiary become covered under another group health plan that does not impose any pre-existing condition exclusion for the qualified beneficiary's pre-existing covered condition covered by COBRA benefits;
- You are no longer disabled as determined by the Social Security Administration (if your COBRA coverage was extended to 29 months due to disability);
- The Commonwealth of Massachusetts or your municipal employer no longer provides group health coverage to any of its employees; or
- Any reason for which the GIC terminates a non-COBRA enrollee's coverage (such as fraud).

The GIC will notify you in writing if your COBRA coverage is to be terminated before the maximum coverage period ends. The GIC reserves the right to terminate your COBRA coverage retroactively if you are subsequently found to have been ineligible for coverage.

HOW AND WHEN DO I ELECT COBRA CONTINUATION COVERAGE?
Qualified beneficiaries must elect COBRA coverage within 60 days of the date that their group coverage otherwise would end or within 60 days of receiving a COBRA notice, whichever is later. A qualified beneficiary may change a prior rejection of COBRA election any time until that date. **If you do not elect COBRA coverage within the 60-day election period, you will lose all rights to COBRA coverage**.

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law, including the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a spouse's plan), even if the plan generally does not, accept late enrollees, if you request enrollment within 30 days after your GIC coverage ends. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you. **Your special enrollment period will end 60 days from the loss of GIC insurance coverage and you may be unable to enroll in other plans; therefore, you should take action right away.**

HOW MUCH DOES COBRA COTINUATION COVERAGE COST?
Under COBRA, you must pay 102% of the applicable cost of your COBRA coverage. If your COBRA coverage is extended to 29 months due to disability, your cost will increase to 150% of the applicable full cost rate for the additional 11 months of coverage. COBRA costs will change periodically; current COBRA rates are included with this notice.

HOW AND WHEN DO I PAY FOR COBRA CONTINUATION COVERAGE?
If you elect COBRA coverage, you must make your first payment for COBRA coverage within 45 days after the date you elect it. **If you do not make your first payment for COBRA coverage within the 45-day period, you will lose all COBRA coverage rights under the plan. You may choose to submit the first payment with your application. If not, you will be billed.**

Your first payment must cover the cost of COBRA coverage from the time your coverage would have ended up to the time you make the first payment. **Services cannot be covered until the GIC receives and processes this first payment, and you are responsible for making sure that the amount of your first payment is enough to cover this entire period**. After you make your first payment, you will be required to pay for COBRA coverage for each subsequent month of coverage. These periodic payments are due usually around the 15th of each month. The GIC will send monthly bills, specifying the due date for payment and the address to which payment is to be sent for COBRA coverage, but **you are responsible for paying for the coverage even if you do not receive a monthly statement**. Payments should be sent to the GIC's address on the bill.

After the first payment, you will have a 30-day grace period beyond the due date on each monthly bill in which to make your monthly payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. **If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA coverage.**

CAN I ELECT OTHER HEALTH COVERAGE BESIDES COBRA?
Yes. You have the right to enroll, within 31 days after coverage ends, in an individual health insurance 'conversion' policy with your current health plan without providing proof of insurability. Alternately, you may purchase health insurance through the Commonwealth's Health Connector Authority or through the Health Insurance Marketplace in other states (see **www.HealthCare.gov** or call 1-800-318-2596). In the Marketplace or Connector, you could be eligible for a tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. The GIC has no involvement in conversion programs and only very limited involvement in the Health Connector programs. You pay the premium to the plan sponsor for the coverage. The benefits provided under such a policy might not be identical to those provided through COBRA. You may exercise this right in lieu of electing COBRA coverage, or you may exercise this right after you have received the maximum COBRA coverage available to you. If you end COBRA coverage early or choose other coverage instead of COBRA, you cannot later switch to COBRA coverage. The Massachusetts Health Connector's website is: **https://www.mahealthconnector.org**. Also, you may be able to determine if you or your dependents qualify for MassHealth through the Connector's website.

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage. If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan, you'll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage. You may want to think about the following when considering different options: What will each premium cost? What are the provider networks and is my doctor in network? What is on the drug formulary for each plan and will my medications be covered? What is the service area of each plan? What will my cost-sharing obligations be? You should consider what your copayments, co-insurance, deductibles, and other amounts will be under each plan.

YOUR COBRA CONTINUATION COVERAGE RESPONSIBILITIES

- **You must inform the GIC of any address changes to preserve your COBRA rights.**
- **You must elect COBRA within 60 days from the date you receive a COBRA notice or would lose group coverage due to one of the qualifying events described above**. If you do not elect COBRA coverage within the 60-day limit, your group health benefits coverage will end, and you will lose all rights to COBRA coverage.
- **You must make the first payment for COBRA coverage within 45 days after you elect COBRA.** If you do not make your first payment for the entire COBRA cost due within that 45-day period, you will lose all COBRA coverage rights.
- **You must pay the subsequent monthly cost for COBRA coverage in full by the end of the 30-day grace period after the due date on the bill**. If you do not make payment in full by the end of the 30-day grace period after the due date on the bill, your COBRA coverage will end.
- **You must inform the GIC within 60 days of the later of either (1) the date of any of the following, or (2) the date on which coverage would be lost because of any of the following events:**
- The employee's job terminates or his/her hours are reduced;
- The insured dies;
- The insured becomes legally separated or divorced;
- The insured or insured's former spouse remarries;
- A covered child ceases to be a dependent under GIC eligibility rules;
- The Social Security Administration determines that the employee or a covered family member is disabled; or
- The Social Security Administration determines that the employee or a covered family member is no longer disabled.

If you do not inform the GIC of these events within the time period specified above, you will lose all rights to COBRA continuation coverage. ***To notify the GIC of any of the above events within the 60 days for providing notice, send a letter to the Public Information Unit at Group Insurance Commission, P.O. Box 556, Randolph, MA 02368.***

If you have questions about COBRA continuation coverage, contact the GIC's Public Information Unit at 617-727-2310, or write to the Unit at P.O. Box 556, Randolph, MA 02368. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration's website at **www.dol.gov/ebsa** or call their toll free number at 866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit **www.healthcare.gov** or, in Massachusetts visit, **https://www.mahealthconnector.org**.

2022.11-GIC-COBRA-ELECTION

The Uniformed Services Employment and Reemployment Rights Act (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects the rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services. The GIC has more generous guidelines for benefit coverage that apply to persons subject to USERRA, as set forth below:

> If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents while in the military.
>
> Service members who elect to continue their GIC health coverage are required to pay the employee's share for such coverage.
>
> Even if you don't elect to continue coverage during your military service, you have the right to be reinstated to GIC health coverage when you are reemployed, generally without any waiting periods or exclusions except for service-connected illnesses or injuries.

The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its website at **http://www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **https://webapps.dol.gov/elaws/vets/userra/mainmenu.asp**. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA. The rights listed here may vary depending on the circumstances.

For more information about your GIC coverage, please contact the Group Insurance Commission at (617) 727-2310.

2021.04-GIC-USERRA

Notice of Group Insurance Commission Privacy Practices

Effective July 1, 2022

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the GIC must protect the privacy and security of your personal health information. The GIC retains this type of information because you receive health benefits from the *Group Insurance Commission*. Under federal law, your health information (known as "protected health information" or "PHI") includes what health plan you are enrolled in and the type of health plan coverage you have. This notice explains your rights and our legal duties and privacy practices.

The GIC will abide by the terms of this notice. Should our information practices materially change, the GIC reserves the right to change the terms of this notice and must abide by the terms of the notice currently in effect. Any new notice provisions will affect all protected health information we already maintain, as well as protected health information that we may receive in the future. We will mail revised notices to the address you have supplied and will post the updated notice on our website at **http://www.mass.gov/gic**.

REQUIRED AND PERMITTED USE AND DISCLOSURES

We typically use or share your health information in the following ways:

Run Our Organization:

- We can use and disclose your information to run our organization and contact you when necessary.
- To operate our programs that include evaluating the quality of health care services you receive and performing analyses to reduce health care costs and improve our health plans performance.
- Arrange for legal and auditing services including fraud and abuse protection.

Pay For Your Health Services:

We can use and disclose your health information as we pay for your health services, administrative fees for health care, and determining eligibility for health benefits.

Provide You With Information On Health-Related Programs Or Products:

This might be information regarding alternative medical treatments or programs or about other health-related services and products.

How Else Can We Use Or Share Your Health Information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues:

We can share health information about you for certain situations such as:

Preventing disease; Helping with product recalls; Reporting adverse reactions to medications; Preventing or reducing a serious threat to anyone's health or safety.

Do research:

We can use or share your information for health research.

Comply with the law:

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law;
- Address workers' compensation, law enforcement, and other government requests;
- For law enforcement purposes or with a law enforcement official;
- With health oversight agencies for activities authorized by law;
- Respond to lawsuits and legal actions;
- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

The GIC May Also Use And Share Your Health Information As Follows:

- to resolve complaints or inquiries made by you or on your behalf (such as an appeal);
- to enable business associates that perform functions on our behalf or provide services if the information is necessary for such functions or service. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract. Our business associates are also directly subject to federal privacy laws;
- for data breach notification purposes. We may use your contact information to provide legally required notice of unauthorized acquisition, access, or disclosure of your health information;
- to verify agency and plan performance (such as audit);
- to communicate with you about your GIC-sponsored benefits (such as your annual benefits statement); and
- to tell you about new or changed benefits and services or health care choices.

Organizations That Assist Us:
In connection with payment and health care operations, we may share your PHI with our third party "Business Associates" that perform activities on our behalf, for example, our Indemnity Plan administrator. When these services are contracted, we may disclose your health information to our business associates, so that they can perform the job we have asked of them. These business associates will be contractually bound to safeguard the privacy of your PHI and also have direct responsibility to protect your PHI imposed by federal law.

When It Comes To Your Health Information, You Have Certain Rights. This section explains your rights and some of our responsibilities to help you.

You have the right to:

Get a copy of your health and claims records:
You can ask to see or get a copy of your health and claims records and other health information we have about you. You must ask for this in writing. Under certain circumstances, we may deny your request. If the GIC did not create the information you seek, we will refer you to the source (e.g., your health plan administrator). We will provide a copy or a summary of your health and claims records. We may charge a reasonable, cost-based fee.

Ask us to correct our records:
You can ask us to correct your health and claims records if you think they are incorrect or incomplete. You must ask for this in writing along with a reason for your request. We may say "no" to your request, but we'll tell you why in writing within 60 days. If we deny your request, you may file a written statement of disagreement to be included with your information for future disclosures.

Request confidential communications:
You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will consider all reasonable requests and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share:
You can ask us not to use or share certain health information for payment or our operations, and disclosures to family members or friends. You must ask for this in writing. We are not required to agree to your request, and in some cases, federal law does not permit a restriction.

Get a list of those with whom we've shared information:
You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make or was part of a limited data set for research).

Get a copy of this privacy notice:
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. (An electronic version of this notice is on our website at **www.mass.gov/gic**.)

Choose someone to act for you:
If you have given someone power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

Receive notification of any breach or your unsecured PHI.

File a complaint if you feel your rights are violated:
You can complain if you feel we have violated your rights by writing to us at GIC Privacy Officer, P.O. Box 566, Randolph, MA 02368. Filing a complaint or exercising your rights will not affect your GIC benefits. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **http://www.hhs.gov/ocr/privacy/hipaa/complaints/**. We will not retaliate against you for filing a complaint. To exercise any of the individual rights described in this notice, or if you need help understanding this notice, please call (617) 727-2310 or TTY for the deaf and hard of hearing at (617) 227-8583.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2022. Contact your state for more information on eligibility –

ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA-Medicaid	**COLORADO-Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS-Medicaid	**FLORIDA-Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA-Medicaid	MAINE-Medicaid
A HIPP Website: https://medicaid.georgia.gov/health-insurance premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711
INDIANA-Medicaid	**MASSACHUSETTS-Medicaid and CHIP**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840
IOWA-Medicaid and CHIP (Hawki)	**MINNESOTA-Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid- a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
KANSAS-Medicaid	**MISSOURI-Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KENTUCKY-Medicaid	**MONTANA-Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
LOUISIANA-Medicaid	**NEBRASKA-Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA-Medicaid	SOUTH CAROLINA-Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEW HAMPSHIRE-Medicaid	**SOUTH DAKOTA-Medicaid**
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW JERSEY-Medicaid and CHIP	**TEXAS-Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW YORK-Medicaid	**UTAH-Medicaid and CHIP**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH CAROLINA-Medicaid	**VERMONT-Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH DAKOTA-Medicaid	**VIRGINIA-Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OKLAHOMA-Medicaid and CHIP	**WASHINGTON-Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
OREGON-Medicaid	**WEST VIRGINIA-Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
PENNSYLVANIA-Medicaid	**WISCONSIN-Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
RHODE ISLAND-Medicaid and CHIP	**WYOMING-Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

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Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

Patient Protection Disclosure

This Plan generally requires the designation of a Primary Care Provider. You have the right to designate any primary care Provider who participates in our network and who is available to accept you and/or your family members. For information on how to select a Primary Care Provider, and for a list of the participating Primary Care Providers, contact Member Services or visit **http://www.tuftshealthplan.com**.

For Children, you may designate a pediatrician as the Primary Care Provider.

You do not need prior authorization from Tufts Health Plan or from any other person (including a Primary Care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment Plan, or procedures for making referrals. For a list of participating health care professionals who specializes in obstetrics or gynecology, contact Member Services or visit **http://www.tuftshealthplan.com**.

Anti-Discrimination Notice

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

Tufts Health Plan:

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

If you need these services, contact Tufts Health Plan at 800.462.0224.

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: 888.880.8699 ext. 48000, [TTY number — 800.439.2370 or 711]
Fax: 617.972.9048
Email: OCRCoordinator@tufts-health.com

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

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

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

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

COVID-19 Testing and Treatment Appendix

Your Group Insurance Commission Member Handbook has been amended as described below with respect to coverage for Coronavirus (COVID-19) testing, treatment, and vaccinations. The following Covered Services are provided in accordance with federal and Massachusetts law.

COVID-19 Testing
Medically Necessary COVID-19 polymerase chain reaction (PCR) and antigen testing is covered for symptomatic individuals, individuals identified as close contacts by state or local health officials, and asymptomatic individuals under circumstances in accordance with federal and Massachusetts law. COVID-19 testing solely intended for return to work, school, or other locations is not Medically Necessary and accordingly not covered.

Antibody tests will be covered when Medically Necessary to support COVID-19 treatments, or for a Member whose immune system is compromised and/or knowledge of COVID-19 antibodies may impact the future outcome of treatment. Antibody tests will not be covered when part of a "return to work" program or when not associated with treatment for COVID-19.

Medically Necessary COVID-19 testing will be covered with no out-of-pocket costs. This means that no Copayment, Coinsurance, or Deductible will apply.

COVID-19 Treatment
Medically Necessary COVID-19-related treatment for all Emergency, Inpatient, Outpatient, and cognitive rehabilitation services—including all professional, diagnostic, and laboratory services—will be covered with no out-of-pocket costs. This means that no Copayment, Coinsurance, or Deductible will apply. Please note that Member cost sharing amounts may apply to Covered Services related to the treatment of reactions to COVID-19 vaccinations.

COVID-19 Vaccinations
Medically Necessary COVID-19-vaccinations are covered with no out-of-pocket costs. This means that no Copayment, Coinsurance, or Deductible will apply.

Please contact Member Services for more information at 800-870-9488.

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Index, *(continued)*

Need to Write or Call?

Tufts Health Plan
P.O. Box 9173
Watertown, MA 02471-9173

800.870.9488

Tufts Health Plan
1 Wellness Way
Canton, MA 02021

For additional information,
please call 800.870.9488

tuftshealthplan.com

Offered by Tufts Benefit Administrators, Inc.

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