TUFTS MEDICARE PREFERRED HMO PLANS | 2019

Summary of Benefits

Employer Group
Tufts Medicare Preferred HMO Prime

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please call Customer Relations to request the "Evidence of Coverage."

Effective January 1, 2019–December 31, 2019
H2256_2019_124_M_EG

TUFTS Health Plan

SUMMARY OF BENEFITS
January 1, 2019 – December 31, 2019

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as Tufts Medicare Preferred HMO Prime).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what Tufts Medicare Preferred HMO Prime covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on http://www.medicare.gov.
- 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 http://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.

Things to Know About Tufts Medicare Preferred HMO Prime

Hours of operation

- From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. Eastern time.
- From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. Eastern time.

Tufts Medicare Preferred HMO Prime phone numbers and website

- If you are a member of this plan, call toll-free 1-800-701-9000 (TTY: 711).
- If you are not a member of this plan, call toll-free 1-800-936-1902 (TTY: 711).
- Our website: thpmp.org

Who can join?

To join Tufts Medicare Preferred HMO Prime, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes the following counties in Massachusetts: Barnstable, Bristol, Essex, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester.

Which doctors, hospitals, and pharmacies can I use?

Tufts Medicare Preferred HMO Prime has a network of doctors, hospitals, pharmacies, and other providers. If you use providers that are not in our network, the plan may not pay for these services.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. You can see our plan's Provider and Pharmacy Directory at our website (thpmp.org). Or, call us and we will send you a copy of the Provider and Pharmacy Directory.

This document is available in other formats such as Braille and large print.

Referral Circles

Your PCP works with certain plan specialists, called a "referral circle," to provide the medical care you need. Your PCP will provide most of your care and will help arrange the rest of the covered services you get as a plan member. In most cases, you must get a referral from your PCP before you see any other health care provider. This means you will not have access to the entire Tufts Medicare Preferred HMO network, except in emergency or urgent care situations, or for out-of-area renal dialysis.

What do we cover?

We cover everything that Original Medicare covers - and more.

- Our plan members get all of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare. For others, you may pay less.
- Our plan members also get more than what is covered by Original Medicare. Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, all plans cover Part B drugs such as chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, thpmp.org.
- Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each medication into one of three "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur after you meet your deductible: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

Monthly Plan Premium	
	Please see your employer for your premium amount.
What You Should Know	In addition, you must keep paying your Medicare Part B premium.
Deductible	
	$300 per year for inpatient hospital care
Maximum Out-of-Pocket Responsibility *(does not include prescription drugs)*	
	$3,400 annually
What You Should Know	Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. If you reach the limit on out-of-pocket costs, we will pay the full cost of your covered hospital and medical services for the rest of the year. Please note that you will still need to pay your monthly premiums (and cost-sharing for your Part D prescription drugs if applicable).
INPATIENT AND OUTPATIENT CARE AND SERVICES	
Inpatient Hospital	
	$300 annual deductible, then you pay nothing
What You Should Know	Our plan covers an unlimited number of days for an inpatient hospital stay. You will not pay more than $300 for inpatient hospital covered services in a calendar year. Prior authorization may be required.
Outpatient Surgery	
Ambulatory surgical center	$50 copay per visit
Outpatient hospital	$50 copay per visit
What You Should Know	Before you receive services, you must obtain a referral from your PCP. Prior authorization may be required.
Doctor Visits	
Primary care physician	$0-10 copay per visit, depending on the service
Specialist	$15 copay per visit
What You Should Know	Before you receive services from a specialist, you must obtain a referral from your PCP.

INPATIENT AND OUTPATIENT CARE AND SERVICES	
Preventive Care	
	You pay nothing
What You Should Know	Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	
	$50 copay per visit
What You Should Know	If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. Your plan includes worldwide coverage for emergency care.
Urgently Needed Services	
	$10-15 copay per visit, depending on the service
What You Should Know	Urgently needed care may be furnished by in-network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. Your plan includes worldwide coverage for urgently needed care.
Diagnostic Services/Labs/Imaging	
Diagnostic radiology services *(such as MRIs, CT scans)*	You pay nothing
Diagnostic tests and procedures	You pay nothing
Lab services	You pay nothing
Outpatient X-rays	You pay nothing
What You Should Know	Prior authorization may be required.
Hearing Services	
Exam to diagnose and treat hearing and balance issues	$15 copay per visit
Routine hearing exam *(up to 1 every year)*	$15 copay per visit
Hearing aids	Up to $500 every three years toward the purchase or repair of hearing aids
What You Should Know	Before you receive a diagnostic hearing exam from a specialist, you must obtain a referral from your PCP.

INPATIENT AND OUTPATIENT CARE AND SERVICES	
Limited Medicare-covered Dental Services	
	$15 copay per visit
What You Should Know	Limited Medicare-covered dental services do not include preventive dental services such as cleaning, routine dental exams, and dental X-rays.
Vision Services	
Annual routine eye exam	$15 copay per visit
Exam to diagnose and treat diseases and conditions of the eye *(including yearly glaucoma screening)*	$0 - 15 copay per visit, depending on the service
Annual eyewear benefit	Up to $150 allowance per calendar year
What You Should Know	You must use a participating vision care provider (EyeMed Vision Care) to receive the covered Routine Eye Exam benefit. You must purchase your glasses, frames, prescription lenses, or contacts from a participating vision provider (EyeMed Vision Care) to receive the $150 allowance. Otherwise, the benefit will be limited to $90 per year. You need a referral from your PCP for a diagnostic eye exam.
Mental Health Services	
Inpatient visit	You pay nothing
Outpatient group or individual therapy visit	$15 copay per visit
What You Should Know	Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental health services provided in a general hospital. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. Before you receive outpatient group or individual therapy visits, you must obtain a referral from your PCP.
Skilled Nursing Facility (SNF)	
	You pay nothing
What You Should Know	Our plan covers up to 100 days in a SNF.

INPATIENT AND OUTPATIENT CARE AND SERVICES	
Physical Therapy	
Occupational therapy	$15 copay per visit
Physical therapy and speech and language therapy	$15 copay per visit
What You Should Know	Before you receive occupational therapy, physical therapy, or speech and language therapy services, you must obtain a referral from your PCP.
Ambulance	
	$50 copay per day
What You Should Know	Prior authorization may be required for non-emergency transportation.
Transportation	
	Not covered
Medicare Part B Drugs	
	For Part B drugs such as chemotherapy drugs: You pay nothing Other Part B drugs: You pay nothing
What You Should Know	Prior authorization may be required.
PRESCRIPTION DRUG BENEFITS	
	Please see the Prescription Drug Coverage Addendum in your enrollment kit for additional information.
ADDITIONAL BENEFITS	
Acupuncture	
Acupuncture services when provided by a licensed acupuncturist	Acupuncture services are eligible for reimbursement under the annual Wellness Allowance benefit. See additional details under "Wellness Programs".
Chiropractic Care	
Manipulation of the spine to correct a subluxation *(when 1 or more of the bones of your spine move out of position)*	$15 copay per visit
What You Should Know	Before you receive services from a specialist, you must obtain a referral from your PCP.

ADDITIONAL BENEFITS	
Foot Care (*podiatry services)*	
Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions	$15 copay per visit
What You Should Know	Before you receive services from a specialist, you must obtain a referral from your PCP.
Home Health Services	
Home Health Agency Care	You pay nothing
Home Health and Infusion Therapy	You pay nothing
What You Should Know	Prior authorization may be required.
Hospice	
	You pay nothing
What You Should Know	You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.
Medical Equipment/Supplies	
Durable Medical Equipment *(e.g., wheelchairs, oxygen)*	You pay nothing
Prosthetic Devices *(braces, artificial limbs, etc.)*	You pay nothing
What You Should Know	Items covered by the plan: bathroom safety equipment for members who have a functional impairment when having the item will improve safety: • Standard raised toilet seat: 1 per member per lifetime • Standard bathroom grab bars: 2 per member per lifetime • Standard tub seat: 1 per member per lifetime The following additional items are covered by the plan: • Gradient compression stockings or surgical stockings: up to 2 pair every 6 months • Mastectomy sleeves for members with upper limb lymphedema: up to 2 pair every 6 months Prior authorization may be required.

ADDITIONAL BENEFITS	
Medical Equipment/Supplies, continued	
Wig allowance (for hair loss due to cancer treatment)	$350 per year
Diabetes Supplies	You pay nothing
What You Should Know	Includes diabetes monitoring supplies, diabetes self-management training, and therapeutic shoes or inserts. Copay may apply if you receive other medical services during the same office visit. Referral required for diabetes self-management training only. Coverage for blood glucose monitors, blood glucose tests strips, and glucose-control solutions is limited to the One Touch products manufactured by Lifescan, Inc. Please note that there is no preferred brand for lancets.
Outpatient Substance Abuse	
Group or individual therapy visit	$15 copay per visit
What You Should Know	Before you receive services from a specialist, you must obtain a referral from your PCP.
Renal Dialysis	
	You pay nothing
Wellness Programs	
Weight Management Program	The plan provides a $150 annual weight management allowance towards program fees for weight loss programs such as WeightWatchers®, Jenny Craig®, or a hospital-based weight loss program.
Wellness Allowance	The plan provides a $150 annual wellness allowance toward a health club memberships, nutritional counseling, acupuncture, or fitness classes like Pilates, Tai Chi, or aerobics, and wellness programs, including memory fitness activities.

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

Tufts Health Plan:

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

If you need these services, contact Tufts Health Plan at 1-800-701-9000 (TTY: 711).

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

Tufts Health Plan, Attention:

Civil Rights Coordinator, Legal Dept.
705 Mount Auburn St., Watertown, MA 02472
Phone: 1-888-880-8699 ext. 48000 (TTY: 711)
Fax: 1-617-972-9048
Email: OCRCoordinator@tufts-health.com

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

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201
1-800-368-1019 (TDD: 1-800-537-7697)

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

thpmp.org | 1-800-701-9000 (TTY: 711)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

QUESTIONS?

Call 1-800-936-1902 // TTY 711

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

VISIT US AT: www.thpmp.org

Tufts Health Plan is an HMO plan with a Medicare contract. Enrollment in Tufts Health Plan depends on contract renewal.

This information is not a complete description of benefits. Call 1-800-701-9000 (TTY: 711) for more information.

TUFTS Health Plan

705 Mount Auburn Street,
Watertown, MA 02472