



# 2022 Summary of Benefits

Tufts Health Plan Medicare Preferred HMO Plans

## **GIC Tufts Health Plan Medicare Preferred HMO**

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 visit [www.tuftshealthplan.com/gic](http://www.tuftshealthplan.com/gic) to view the *Evidence of Coverage*. You can also request a printed copy by calling Member Services at 1-855-852-1016 (TTY: 711).

# Summary of Benefits July 1, 2022–June 30, 2023

## 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 Health Plan Medicare Preferred HMO).

## Tips for comparing your Medicare choices

This *Summary of Benefits* booklet gives you a summary of what GIC Tufts Health Plan Medicare Preferred HMO 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 [www.medicare.gov](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 [www.medicare.gov](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 GIC Tufts Health Plan Medicare Preferred HMO

### Who can join?

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

The service area for the plan described in this document 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?

GIC Tufts Health Plan Medicare Preferred HMO 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 can see our plan's *Provider Directory* at our website ([www.tuftshealthplan.com/gic](http://www.tuftshealthplan.com/gic)).

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

<b>Monthly Plan Premium</b>	
	Please contact the Group Insurance Commission for your premium amount.
<b>Deductible</b>	
	There is no deductible for this plan.
<b>Maximum Out-of-Pocket Responsibility</b> (does not include prescription drugs)	\$3,400
<b>What You Should Know</b>	<p>Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.</p> <p>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).</p>
<b>Inpatient and Outpatient Care and Services</b>	
<b>Inpatient Hospital Care</b>	
<b>Inpatient hospital care</b>	You pay nothing
<b>What You Should Know</b>	<p>Our plan covers an unlimited number of days for an inpatient hospital stay. Prior authorization may be required.</p>
<b>Outpatient Hospital Care</b>	
<b>Outpatient hospital services</b>	You pay nothing
<b>Outpatient surgery</b> (services provided at hospital outpatient facilities and ambulatory surgical centers)	You pay nothing
<b>What You Should Know</b>	<p>Before you receive services, you must obtain a referral from your PCP. Prior authorization may be required.</p>
<b>Doctor Visits</b>	
<b>Primary care physician</b>	\$15 copay per visit
<b>Specialist</b>	\$15 copay per visit
<b>What You Should Know</b>	<p>There is no copay for an annual physical exam with your PCP. PCP cost share may apply if non-preventive services are rendered during the same office visit. Before you receive services from a specialist, you must obtain a referral from your PCP.</p>
<b>Preventive care</b>	You pay nothing
<b>What You Should Know</b>	<p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>
<b>Emergency care</b>	\$50 copay per visit
<b>What You Should Know</b>	<p>If you are admitted to the hospital within 24 hours for the same condition, you do not have to pay your share of the cost for emergency care. Outpatient surgery copayment may apply in certain situations. Please refer to your <i>Evidence of Coverage</i> for more information.</p> <p>Your plan includes worldwide coverage for emergency care.</p>
<b>Urgently needed services</b>	\$15 copay per visit

Inpatient and Outpatient Care and Services	
<b>What You Should Know</b>	<p>Urgently needed care may be furnished by in-network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. Copayment is not waived if admitted as an inpatient within 24 hours.</p> <p>Your plan includes worldwide coverage for urgently needed care.</p>
Diagnostic Services/Labs/Imaging	
<b>Diagnostic radiology services</b> (such as MRIs, CT scans)	You pay nothing
<b>Diagnostic tests and procedures</b>	You pay nothing
<b>Lab services</b>	You pay nothing
<b>Outpatient X-rays</b>	You pay nothing
<b>What You Should Know</b>	Prior authorization may be required.
Hearing Services	
<b>Exam to diagnose and treat hearing and balance issues</b>	\$15 copay per visit
<b>Routine hearing exam</b> (up to 1 every year)	\$15 copay per visit
<b>Hearing aids</b>	Members 22 and over - First \$500 covered in full by the plan; member pays 20% of the cost for the next \$1,500 (for both ears combined). Plan coverage is limited to \$1,700 per member every 24 months. Member is responsible for any amount over \$1,700 every two years.
<b>What You Should Know</b>	Before you receive a diagnostic hearing exam from a specialist, you must obtain a referral from your PCP.
Dental	
<b>Limited Medicare-covered dental services</b>	\$15 copay per visit
<b>What You Should Know</b>	Limited Medicare-covered dental services do not include preventive dental services such as cleaning, routine dental exams, and dental X-rays.
Vision Services	
<b>Routine eye exam</b> (up to 1 every year)	\$15 copay per visit
<b>Exam to diagnose and treat diseases and conditions of the eye</b>	\$15 copay per visit
<b>Annual glaucoma screening</b>	You pay nothing
<b>Annual eyewear benefit</b>	Up to \$150 allowance per calendar year
<b>What You Should Know</b>	You must use a participating vision care provider (EyeMed Vision Care) to receive the covered Routine Eye Exam benefit. You must purchase your glasses (prescription lenses, frames, or a combination of lenses and frames) and/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.

<b>Inpatient and Outpatient Care and Services</b>	
<b>Mental Health Services</b>	
<b>Inpatient visit</b>	You pay nothing
<b>Outpatient group or individual therapy visit</b>	\$15 copay per visit
<b><i>What You Should Know</i></b>	<p>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.</p> <p>Before you receive outpatient group or individual therapy visits, you must obtain a referral from your PCP.</p>
<b>Skilled Nursing Facility (SNF)</b>	
<b>Skilled nursing facility (SNF)</b>	You pay nothing
<b><i>What You Should Know</i></b>	Our plan covers up to 100 days in a SNF per benefit period. No prior hospital stay is required.
<b>Physical Therapy</b>	
<b>Occupational therapy</b>	You pay nothing
<b>Physical therapy and speech and language therapy</b>	You pay nothing
<b><i>What You Should Know</i></b>	Before you receive occupational therapy, physical therapy, or speech and language therapy services, you must obtain a referral from your PCP.
<b>Ambulance</b>	
<b>Ambulance</b>	You pay nothing
<b><i>What You Should Know</i></b>	Prior authorization may be required for non-emergency transportation.
<b>Transportation</b>	
<b>Transportation</b>	Not covered
<b>Medicare Part B Drugs</b>	
<b>Medicare Part B drugs</b>	<p>For Part B chemotherapy drugs: You pay nothing.</p> <p>Other Part B drugs: You pay nothing.</p>
<b><i>What You Should Know</i></b>	Prior authorization may be required.
<b>Prescription Drug Benefits</b>	
<p>Your prescription drug benefits will be managed by CVS SilverScript®. If you have questions or would like information about the formulary (list of covered drugs), call the CVS SilverScript customer relations department at <b>1-877-876-7214</b>, or visit <a href="https://gic.silverscript.com">gic.silverscript.com</a>.</p>	

Additional Benefits	
Acupuncture	
Acupuncture services	\$15 copay per visit
<b>What You Should Know</b>	<p>Medicare covers up to 12 visits in 90 days for members with chronic low back pain. 8 additional visits covered for those demonstrating an improvement. No more than 20 visits administered annually.</p> <p>Before you receive services from a specialist, you must obtain a referral from your PCP.</p> <p>The plan will reimburse services rendered and billed directly by a licensed acupuncturist when there is a referral from your PCP.</p> <p>Additional acupuncture services are eligible for reimbursement under the annual Wellness Allowance benefit. See additional details under “Wellness Programs.”</p>
Chiropractic Care	
<b>Manual manipulation of the spine to correct a subluxation</b> (when 1 or more of the bones of your spine move out of position)	\$15 copay per visit
<b>What You Should Know</b>	Before you receive services from a specialist, you must obtain a referral from your PCP.
Foot Care (podiatry services)	
<b>Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions</b>	\$15 copay per visit
<b>What You Should Know</b>	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 infusion therapy	You pay nothing
<b>What You Should Know</b>	Prior authorization may be required for home infusion therapy services.
Hospice	
	Benefit provided by Medicare
<b>What You Should Know</b>	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	
<b>Durable medical equipment</b> (e.g., wheelchairs, oxygen)	You pay nothing
<b>Prosthetic devices</b> (e.g., braces, artificial limbs, etc.)	You pay nothing

Additional Benefits	
<b>What You Should Know</b>	<p>Additional items covered by the plan: bathroom safety equipment for members who have a functional impairment when having the item will improve safety:</p> <ul style="list-style-type: none"> <li>• Raised toilet seat: 1 per member per lifetime</li> <li>• Bathroom grab bars: 2 per member per lifetime</li> <li>• Tub seat: 1 per member per lifetime</li> <li>• The following additional items are covered by the plan:</li> <li>• Gradient compression stockings or surgical stockings: up to 2 pairs every 6 months</li> <li>• Mastectomy sleeves for members with upper limb lymphedema: up to 2 sleeves every 6 months</li> </ul> <p>Prior authorization may be required.</p>
<b>Wig allowance</b> (for hair loss due to cancer treatment)	\$350 per calendar year
<b>Diabetes services and supplies</b>	You pay nothing
<b>What You Should Know</b>	<p>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.</p> <p>Coverage for blood glucose monitors and blood glucose tests strips is limited to the OneTouch products manufactured by Lifescan, Inc. Please note that there is no preferred brand for lancets or glucose control solutions.</p> <p>Covered therapeutic Continuous Glucose Monitors (CGMs) include Dexcom and FreeStyle Libre products. Prior authorization may be required before you receive therapeutic CGMs.</p> <p>Diabetic testing supplies, including test strips, lancets, glucose meters, and Therapeutic Continuous Glucose Monitoring Systems are also covered at participating retail or mail-order pharmacies.</p>
Outpatient Substance Abuse	
<b>Group or individual therapy visit</b>	\$15 copay per visit
<b>What You Should Know</b>	Before you receive services from a specialist, you must obtain a referral from your PCP.
Renal Dialysis	
	You pay nothing
Telehealth/Telemedicine Services	
	<p>Medicare-covered services plus additional telehealth services including PCP services, specialist services, and more.</p> <p>\$0 copay for e-visits and virtual check-ins; For all other telehealth visits, copay is the same as corresponding in-person visit copay. The same referral rules apply to telehealth services as for corresponding in-person visits.</p>
Wellness Programs	
<b>Weight Management program</b>	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.
<b>Wellness Allowance</b>	The plan provides a \$150 annual Wellness Allowance toward health club memberships, participation in online instructional fitness classes or membership fees for online fitness subscriptions, such as Peloton, 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, sex, sexual orientation, or gender identity.**

**Tufts Health Plan:**

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

If you need these services, contact Tufts Health Plan at 1-800-701-9000 (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, sex, sexual orientation, or gender identity, you can file a grievance with:

**Tufts Health Plan, Attention:**

Civil Rights Coordinator, Legal Dept.  
1 Wellness Way, Canton, MA 02021  
Phone: 1-888-880-8699 ext. 48000, (TTY: 711)  
Fax: 1-617-972-9048  
Email: [OCRCoordinator@point32health.org](mailto:OCRCoordinator@point32health.org)

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

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

**U.S. Department of Health and Human Services**

200 Independence Avenue, SW  
Room 509F, HHH Building Washington, D.C. 20201  
1-800-368-1019 (TDD: 1-800-537-7697)

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

[thpmp.org](http://thpmp.org) | 1-800-701-9000 (TTY: 711)

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**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:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-701-9000 (TTY: 711) 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 નિઃશુલ્ક 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 ដោយមិនគិតល្បួល 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, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-701-9000 (TTY: 711).

**Navajo:** Díí baa akó nínízin: Díí saad bee yánílt'igo Diné Bizaad, saad bee áká'ánídaáwo'dęę, t'áá jiikeh, 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

Visit us at [www.tuftshealthplan.com/gic](http://www.tuftshealthplan.com/gic), or call 1-855-852-1016 (TTY: 711).



1 Wellness Way  
Canton, MA 02021