TUFTS Health Plan

a Point32Health company

2024 Summary of Benefits

Tufts Medicare Preferred HMO Plans

This *Summary of Benefits* covers plans in the following counties in Massachusetts: **Barnstable, Bristol, Essex, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester.**

Tufts Medicare Preferred HMO Smart Saver Rx (HMO)
Tufts Medicare Preferred HMO Saver Rx (HMO)
Tufts Medicare Preferred HMO Basic No Rx (HMO)
Tufts Medicare Preferred HMO Basic Rx (HMO)
Tufts Medicare Preferred HMO Value No Rx (HMO)
Tufts Medicare Preferred HMO Value Rx (HMO)
Tufts Medicare Preferred HMO Prime No Rx (HMO)
Tufts Medicare Preferred HMO Prime Rx (HMO)
Tufts Medicare Preferred HMO Prime Rx Plus (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.thpmp.org** to view the *Evidence of Coverage*. You can also request a printed copy by calling Member Services at 1-800-701-9000 (TTY: 711), 8:00 a.m. – 8:00 p.m., 7 days a week from October 1 to March 31 and Monday-Friday from April 1 to September 30.

Effective January 1, 2024–December 31, 2024

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Summary of Benefits January 1, 2024–December 31, 2024

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).

Tips for comparing your Medicare choices

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

- If you want to compare our plans with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder at **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** 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

Who can join?

To join Tufts 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 plans 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?

Tufts Medicare Preferred HMO has a network of doctors, hospitals, pharmacies, and other providers. If you use providers that are not in our network, the plans 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 plans' *Provider Directory* and *Pharmacy Directory* at our website (**www.thpmp.org**).

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 less in our plans 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.

Tufts Medicare Preferred HMO Smart Saver Rx, Tufts Medicare Preferred HMO Saver Rx, Tufts Medicare Preferred HMO Basic Rx, Tufts Medicare Preferred HMO Value Rx, Tufts Medicare Preferred HMO Prime Rx, and Tufts Medicare Preferred HMO Prime Rx Plus cover Part D drugs, as well as enhanced coverage of certain drugs such as select erectile dysfunction (ED) drugs, vitamins and minerals, and cough/cold products. 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, **www.thpmp.org**.

How will I determine my drug costs for Tufts Medicare Preferred HMO Smart Saver Rx, Tufts Medicare Preferred HMO Saver Rx, Tufts Medicare Preferred HMO Basic Rx, Tufts Medicare Preferred HMO Value Rx, Tufts Medicare Preferred HMO Prime Rx, and Tufts Medicare Preferred HMO Prime Rx Plus?

Our plans group each medication into one of six "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, the Coverage Gap, and Catastrophic Coverage.

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

	Tufts Medicare Preferred **HMO Smart Saver Rx**	Tufts Medicare Preferred **HMO Saver Rx**	Tufts Medicare Preferred **HMO Basic No Rx**	Tufts Medicare Preferred **HMO Basic Rx**
Monthly Plan Premium				
Middlesex, Norfolk, Plymouth, Barnstable, Bristol	$0 per month	$0 per month	Not offered	$51 per month
Essex, Suffolk	$0 per month	$0 per month	$28 per month	$61 per month
Hampden, Hampshire	$0 per month	$0 per month	Not offered	$40 per month
Worcester	$0 per month	$0 per month	$20 per month	$43 per month
What You Should Know	In addition, you must keep paying your Medicare Part B premium.			
Deductible (for Part D prescription drugs)	This plan does not have a deductible.	$250 per year for your Tier 3, Tier 4, and Tier 5 drugs	This plan does not cover prescription drugs.	$225 per year for your Tier 3, Tier 4, and Tier 5 drugs
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$5,900	$7,550	$3,650	$3,650
What You Should Know	Like all Medicare health plans, our plans protect 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	Tufts Medicare Preferred **HMO Smart Saver Rx**	Tufts Medicare Preferred **HMO Saver Rx**	Tufts Medicare Preferred **HMO Basic No Rx**	Tufts Medicare Preferred **HMO Basic Rx**
Inpatient Hospital Care				
Inpatient hospital care	$380 copay per day for days 1 through 5; $0 copay for day 6 and beyond	$350 copay per day for days 1 through 5; $0 copay for day 6 and beyond	$275 copay per day for days 1 through 5; $0 copay for day 6 and beyond	$275 copay per day for days 1 through 5; $0 copay for day 6 and beyond
What You Should Know	Our plans cover an unlimited number of days for an inpatient hospital stay. Prior authorization may be required.			
Outpatient Hospital Care				
Outpatient hospital services	$370 copay per day	$370 copay per day	$270 copay per day	$270 copay per day
Outpatient surgery (services provided at hospital outpatient facilities)	Colonoscopies: $0 copay; Other services: $370 copay per day	Colonoscopies: $0 copay; Other services: $370 copay per day	Colonoscopies: $0 copay; Other services: $270 copay per day	Colonoscopies: $0 copay; Other services: $270 copay per day
Ambulatory surgical center (ASC) services	Colonoscopies: $0 copay; Other services: $270 copay per day	Colonoscopies: $0 copay; Other services: $270 copay per day	Colonoscopies: $0 copay; Other services: $170 copay per day	Colonoscopies: $0 copay; Other services: $170 copay per day
What You Should Know	Before you receive services, you must obtain a referral from your PCP. Prior authorization may be required.			

Tufts Medicare Preferred **HMO Value No Rx**	Tufts Medicare Preferred **HMO Value Rx**	Tufts Medicare Preferred **HMO Prime No Rx**	Tufts Medicare Preferred **HMO Prime Rx**	Tufts Medicare Preferred **HMO Prime Rx Plus**
Monthly Plan Premium				
$103 per month	$159 per month	$133 per month	$186 per month	$220 per month
$123 per month	$181 per month	$156 per month	$216 per month	$248 per month
Not offered	$89 per month	Not offered	$109 per month	$129 per month
$112 per month	$166 per month	$152 per month	$196 per month	Not offered
In addition, you must keep paying your Medicare Part B premium.				
This plan does not cover prescription drugs.	This plan does not have a deductible.	This plan does not cover prescription drugs.	This plan does not have a deductible.	This plan does not have a deductible.

$3,650	$3,650	$3,650	$3,650	$3,650
Like all Medicare health plans, our plans protect 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).				

Tufts Medicare Preferred **HMO Value No Rx**	Tufts Medicare Preferred **HMO Value Rx**	Tufts Medicare Preferred **HMO Prime No Rx**	Tufts Medicare Preferred **HMO Prime Rx**	Tufts Medicare Preferred **HMO Prime Rx Plus**
Inpatient hospital care				
$200 copay per day for days 1 through 5; $0 copay for day 6 and beyond	$200 copay per day for days 1 through 5; $0 copay for day 6 and beyond	$300 copay per stay. You will not pay more than $900 for inpatient hospital covered services in a calendar year.	$300 copay per stay. You will not pay more than $900 for inpatient hospital covered services in a calendar year.	$200 copay per stay. You will not pay more than $400 for inpatient hospital covered services in a calendar year.
Our plans cover an unlimited number of days for an inpatient hospital stay. Prior authorization may be required.				
Outpatient hospital care				
$150 copay per day	$150 copay per day	$100 copay per day	$100 copay per day	$75 copay per day
Colonoscopies: $0 copay; Other services: $150 copay per day	Colonoscopies: $0 copay; Other services: $150 copay per day	Colonoscopies: $0 copay; Other services: $100 copay per day	Colonoscopies: $0 copay; Other services: $100 copay per day	Colonoscopies: $0 copay; Other services: $75 copay per day
Colonoscopies: $0 copay; Other services: $150 copay per day	Colonoscopies: $0 copay; Other services: $150 copay per day	Colonoscopies: $0 copay; Other services: $100 copay per day	Colonoscopies: $0 copay; Other services: $100 copay per day	Colonoscopies: $0 copay; Other services: $75 copay per day
Before you receive services, you must obtain a referral from your PCP. Prior authorization may be required.				

Inpatient and Outpatient Care and Services	Tufts Medicare Preferred **HMO Smart Saver Rx**	Tufts Medicare Preferred **HMO Saver Rx**	Tufts Medicare Preferred **HMO Basic No Rx**	Tufts Medicare Preferred **HMO Basic Rx**
Doctor Visits				
Primary care physician	$0 copay per visit	$10 copay per visit	$10 copay per visit	$10 copay per visit
Specialist	$45 copay per visit	$45 copay per visit	$40 copay per visit	$40 copay per visit
What You Should Know	There is no copay for an annual physical exam with your PCP. Office visit copay applies for surgery services furnished in the physician's office. Before you receive services from a specialist, you must obtain a referral from your PCP.			
Preventive care	$0 copay	$0 copay	$0 copay	$0 copay
What You Should Know	Any additional preventive services approved by Medicare during the contract year will be covered.			
Emergency care	$90 copay per visit	$90 copay per visit	$110 copay per visit	$110 copay per visit
What You Should Know	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. Your plan includes worldwide coverage for emergency care.			
Urgently needed services	$50 copay per visit	$50 copay per visit	$50 copay per visit	$50 copay per visit
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. Copayment is not waived if admitted as an inpatient within 24 hours. Your plan includes worldwide coverage for urgently needed care.			
Diagnostic Services/Labs/Imaging				
Diagnostic radiology services (such as MRIs, CT scans)	$100 copay per day for ultrasound; $350 copay per day for all other services	$100 copay per day for ultrasound; $325 copay per day for all other services	$100 copay per day for ultrasound; $250 copay per day for all other services	$100 copay per day for ultrasound; $250 copay per day for all other services
Diagnostic tests and procedures	$20 copay per day	$20 copay per day	$20 copay per day	$20 copay per day
Lab services	$0 copay	$0 copay	$0 copay	$0 copay
Outpatient X-rays	$20 per day	$20 per day	$20 per day	$20 per day
What You Should Know	Diagnostic tests and procedures, lab services, and outpatient X-rays performed and billed as part of an office visit or urgent care visit will not pull a separate copay in addition to the applicable office visit or urgent care copay. Prior authorization may be required.			
Hearing Services				
Exam to diagnose and treat hearing and balance issues	$45 copay per visit	$45 copay per visit	$40 copay per visit	$40 copay per visit
Routine hearing exam (up to 1 every year)	$0 copay	$0 copay	$0 copay	$0 copay
Hearing aids	Standard level: $250 copay per hearing aid; Superior level: $475 copay per hearing aid; Advanced level: $650 copay per hearing aid; Advanced Plus level: $850 copay per hearing aid; Premier level: $1,150 copay per hearing aid.			
What You Should Know	You must purchase hearing aids through Hearing Care Solutions to receive the Hearing Aid benefit. Up to 2 hearing aids per year, 1 hearing aid per ear. Hearing aid fitting is provided by Hearing Care Solutions at no cost.			
Dental				
Limited Medicare-covered dental services	$45 copay per visit	$45 copay per visit	$40 copay per visit	$40 copay per visit

Tufts Medicare Preferred **HMO Value No Rx**	Tufts Medicare Preferred **HMO Value Rx**	Tufts Medicare Preferred **HMO Prime No Rx**	Tufts Medicare Preferred **HMO Prime Rx**	Tufts Medicare Preferred **HMO Prime Rx Plus**
Doctor Visits				
$10 copay per visit	$10 copay per visit	$10 copay per visit	$10 copay per visit	$10 copay per visit
$25 copay per visit	$25 copay per visit	$15 copay per visit	$15 copay per visit	$15 copay per visit
There is no copay for an annual physical exam with your PCP. Office visit copay applies for surgery services furnished in the physician's office. Before you receive services from a specialist, you must obtain a referral from your PCP.				
$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Any additional preventive services approved by Medicare during the contract year will be covered.				
$110 copay per visit	$110 copay per visit	$110 copay per visit	$110 copay per visit	$110 copay per visit
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. Your plan includes worldwide coverage for emergency care.				
$30 copay per visit	$30 copay per visit	$30 copay per visit	$30 copay per visit	$30 copay per visit
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. Your plan includes worldwide coverage for urgently needed care.				
Diagnostic Services/Labs/Imaging				
$100 copay per day	$100 copay per day	20% of the cost. You will not pay more than $75 per day for diagnostic radiology services.	20% of the cost. You will not pay more than $75 per day for diagnostic radiology services.	20% of the cost. You will not pay more than $75 per day for diagnostic radiology services.
$10 copay per day	$10 copay per day	$0 copay	$0 copay	$0 copay
$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
$10 per day	$10 per day	$0 copay	$0 copay	$0 copay
Diagnostic tests and procedures, lab services, and outpatient X-rays performed and billed as part of an office visit or urgent care visit will not pull a separate copay in addition to the applicable office visit or urgent care copay. Prior authorization may be required.				
Hearing Services				
$25 copay per visit	$25 copay per visit	$15 copay per visit	$15 copay per visit	$15 copay per visit
$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Standard level: $250 copay per hearing aid; Superior level: $475 copay per hearing aid; Advanced level: $650 copay per hearing aid; Advanced Plus level: $850 copay per hearing aid; Premier level: $1,150 copay per hearing aid.				
You must purchase hearing aids through Hearing Care Solutions to receive the Hearing Aid benefit. Up to 2 hearing aids per year, 1 hearing aid per ear. Hearing aid fitting is provided by Hearing Care Solutions at no cost.				
Dental				
$25 copay per visit	$25 copay per visit	$15 copay per visit	$15 copay per visit	$15 copay per visit

Inpatient and Outpatient Care and Services	Tufts Medicare Preferred **HMO Smart Saver Rx**	Tufts Medicare Preferred **HMO Saver Rx**	Tufts Medicare Preferred **HMO Basic No Rx**	Tufts Medicare Preferred **HMO Basic Rx**
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.			
Embedded dental benefit	• $2,500 calendar year maximum. • $0 copay for preventive services such as routine cleanings, oral exams, and bitewing x-rays; 20% coinsurance for basic services such as fillings and x-rays other than bitewing images; and 50% coinsurance for major services such as extractions, dentures, bridges, and crowns. • $0 deductible. • No waiting period.	• $1,000 calendar year maximum. • $0 copay for preventive services such as cleaning and oral exams, and 50% coinsurance for basic services such as fillings and simple extractions. • No deductible. • No waiting period.	• $1,000 calendar year maximum. • $0 copay for preventive services such as cleaning and oral exams, and 50% coinsurance for basic services such as fillings and simple extractions. • No deductible. • No waiting period.	• $1,000 calendar year maximum. • $0 copay for preventive services such as cleaning and oral exams, and 50% coinsurance for basic services such as fillings and simple extractions. • No deductible. • No waiting period.
What You Should Know	Coverage is limited to providers within the Dominion PPO network. Other benefit limits apply.			
Tufts Medicare Preferred Dental Option	N/A	Covered with additional premium. See the Optional Benefits section for more information.		
Vision Services				
Routine eye exam (up to 1 every year)	$15 copay per visit	$15 copay per visit	$15 copay per visit	$15 copay per visit
Exam to diagnose and treat diseases and conditions of the eye	$45 copay per visit	$45 copay per visit	$40 copay per visit	$40 copay per visit
Annual glaucoma screening	$0 copay per visit	$0 copay per visit	$0 copay per visit	$0 copay per visit
Annual eyewear benefit	Up to $150 allowance per calendar year	Up to $150 allowance per calendar year	Up to $150 allowance per calendar year	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, 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.			
Mental Health Services				
Inpatient visit	$370 copay per day for days 1 through 5; $0 copay for day 6 and beyond.	$350 copay per day for days 1 through 5; $0 copay for day 6 and beyond.	$275 copay per day for days 1 through 5; $0 copay for day 6 and beyond.	$275 copay per day for days 1 through 5; $0 copay for day 6 and beyond.
Outpatient group or individual therapy visit	$25 copay per visit	$25 copay per visit	$25 copay per visit	$25 copay per visit

Tufts Medicare Preferred **HMO Value No Rx**	Tufts Medicare Preferred **HMO Value Rx**	Tufts Medicare Preferred **HMO Prime No Rx**	Tufts Medicare Preferred **HMO Prime Rx**	Tufts Medicare Preferred **HMO Prime Rx Plus**
Limited Medicare-covered dental services do not include preventive dental services such as cleaning, routine dental exams, and dental X-rays.				
• $1,000 calendar year maximum. • $0 copay for preventive services such as cleaning and oral exams, and 50% coinsurance for basic services such as fillings and simple extractions. • No deductible. • No waiting period.	• $1,000 calendar year maximum. • $0 copay for preventive services such as cleaning and oral exams, and 50% coinsurance for basic services such as fillings and simple extractions. • No deductible. • No waiting period.	Not covered	Not covered	Not covered
Coverage is limited to providers within the Dominion PPO network. Other benefit limits apply.		N/A	N/A	N/A
Covered with additional premium. See the Optional Benefits section for more information.				
Vision Services				
$15 copay per visit	$15 copay per visit	$15 copay per visit	$15 copay per visit	$15 copay per visit
$25 copay per visit	$25 copay per visit	$15 copay per visit	$15 copay per visit	$15 copay per visit
$0 copay per visit	$0 copay per visit	$0 copay per visit	$0 copay per visit	$0 copay per visit
Up to $150 allowance per calendar year	Up to $150 allowance per calendar year	Up to $150 allowance per calendar year	Up to $150 allowance per calendar year	Up to $150 allowance per calendar year
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, 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.				
Mental Health Services				
$200 copay per day for days 1 through 5; $0 copay for day 6 and beyond.	$200 copay per day for days 1 through 5; $0 copay for day 6 and beyond.	$300 copay per stay. You will not pay more than $900 for inpatient hospital covered services in a calendar year.	$300 copay per stay. You will not pay more than $900 for inpatient hospital covered services in a calendar year.	$200 copay per stay. You will not pay more than $400 for inpatient hospital covered services in a calendar year.
$20 copay per visit	$20 copay per visit	$10 copay per visit	$10 copay per visit	$10 copay per visit

Inpatient and Outpatient Care and Services	Tufts Medicare Preferred **HMO Smart Saver Rx**	Tufts Medicare Preferred **HMO Saver Rx**	Tufts Medicare Preferred **HMO Basic No Rx**	Tufts Medicare Preferred **HMO Basic Rx**
What You Should Know	Our plans cover 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. Before you receive services from a psychiatrist, you must obtain a referral from your PCP. A referral is not required for all other Outpatient Mental Health Care services.			
Skilled Nursing Facility (SNF)				
Skilled nursing facility (SNF)	$0 copay per day for days 1 through 20; $180 copay per day for days 21 through 44; $0 copay per day for days 45 through 100	$0 copay per day for days 1 through 20; $180 copay per day for days 21 through 44; $0 copay per day for days 45 through 100	$20 copay per day for days 1 through 20; $160 copay per day for days 21 through 44; $0 copay per day for days 45 through 100	$20 copay per day for days 1 through 20; $160 copay per day for days 21 through 44; $0 copay per day for days 45 through 100
What You Should Know	Our plans cover up to 100 days in a SNF per benefit period. No prior hospital stay is required. Prior authorization may be required.			
Physical Therapy				
Occupational therapy	$40 copay per visit	$40 copay per visit	$30 copay per visit	$30 copay per visit
Physical therapy and speech and language therapy	$40 copay per visit	$40 copay per visit	$30 copay per visit	$30 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				
Ambulance	$350 copay per one-way trip	$350 copay per one-way trip	$325 copay per one-way trip	$325 copay per one-way trip
What You Should Know	Prior authorization may be required for non-emergency transportation.			
Transportation				
Transportation	$40 copay per ride	$40 copay per ride	$40 copay per ride	$40 copay per ride
What You Should Know	Non-ambulance transportation (e.g., by chair car/wheelchair van or sedan) through the plan-approved vendor from a hospital to a skilled nursing facility when ordered by the discharging hospital.			
Medicare Part B Drugs				
Medicare Part B drugs	For Part B chemotherapy drugs: You pay up to 20% of the cost; Insulin: $35 copay per 30-day supply; Other Part B drugs: You pay up to 20% of the cost.			
What You Should Know	Your actual coinsurance rate for non-insulin Medicare Part B drugs each quarter will vary based on adjustment for applicable rebates supplied by Medicare. Your coinsurance will not exceed 20% for all non-insulin Medicare Part B prescription drugs. Prior authorization may be required. Part B drugs may be subject to Step Therapy requirements.			

Tufts Medicare Preferred **HMO Value No Rx**	Tufts Medicare Preferred **HMO Value Rx**	Tufts Medicare Preferred **HMO Prime No Rx**	Tufts Medicare Preferred **HMO Prime Rx**	Tufts Medicare Preferred **HMO Prime Rx Plus**
Our plans cover 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. Before you receive services from a psychiatrist, you must obtain a referral from your PCP. A referral is not required for all other Outpatient Mental Health Care services.				
Skilled Nursing Facility (SNF)				
$20 copay per day for days 1 through 20; $120 copay per day for days 21 through 44; $0 copay per day for days 45 through 100	$20 copay per day for days 1 through 20; $120 copay per day for days 21 through 44; $0 copay per day for days 45 through 100	$20 copay per day for days 1 through 20; $80 copay per day for days 21 through 44; $0 copay per day for days 45 through 100	$20 copay per day for days 1 through 20; $80 copay per day for days 21 through 44; $0 copay per day for days 45 through 100	$20 copay per day for days 1 through 20; $0 copay per day for days 21 through 100
Our plans cover up to 100 days in a SNF per benefit period. No prior hospital stay is required. Prior authorization may be required.				
Physical Therapy				
$20 copay per visit	$20 copay per visit	$15 copay per visit	$15 copay per visit	$15 copay per visit
$20 copay per visit	$20 copay per visit	$15 copay per visit	$15 copay per visit	$15 copay per visit
Before you receive occupational therapy, physical therapy, or speech and language therapy services, you must obtain a referral from your PCP.				
Ambulance				
$225 copay per one-way trip	$225 copay per one-way trip	$125 copay per one-way trip	$125 copay per one-way trip	$90 copay per one-way trip
Prior authorization may be required for non-emergency transportation.				
Transportation				
$40 copay per ride	$40 copay per ride	$40 copay per ride	$40 copay per ride	$40 copay per ride
Non-ambulance transportation (e.g., by chair car/wheelchair van or sedan) through the plan-approved vendor from a hospital to a skilled nursing facility when ordered by the discharging hospital.				
Medicare Part B Drugs				
For Part B chemotherapy drugs: $0 copay; Insulin: $0 copay per 30-day supply; Other Part B drugs: $0 copay.				
Prior authorization may be required. Part B drugs may be subject to Step Therapy requirements.				

Prescription Drug Benefits: Deductible (for Part D prescription drugs)	Tufts Medicare Preferred **HMO Smart Saver Rx**	Tufts Medicare Preferred **HMO Saver Rx**	Tufts Medicare Preferred **HMO Basic No Rx**	Tufts Medicare Preferred **HMO Basic Rx**
Deductible	This plan does not have a deductible.	$250 per year for your Tier 3, Tier 4, and Tier 5 drugs	This plan does not cover Part D prescription drugs	$225 per year for your Tier 3, Tier 4, and Tier 5 drugs

Prescription Drug Benefits: Initial Coverage	Tufts Medicare Preferred **HMO Smart Saver Rx**	Tufts Medicare Preferred **HMO Saver Rx**	Tufts Medicare Preferred **HMO Basic No Rx**	Tufts Medicare Preferred **HMO Basic Rx**
Note: Tier 1 and Tier 2 drugs include enhanced coverage of certain drugs such as select erectile dysfunction (ED) drugs, and vitamins.	You pay the following until your total yearly drug costs reach $5,030. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.	After you pay your yearly deductible of $250 for Tier 3, Tier 4, and Tier 5 drugs, you pay the following until your total yearly drug costs reach $5,030. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.	This plan does not cover Part D prescription drugs	After you pay your yearly deductible of $225 for Tier 3, Tier 4, and Tier 5 drugs, you pay the following until your total yearly drug costs reach $5,030. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.

Prescription Drug Benefits: Initial Coverage	Tufts Medicare Preferred **HMO Smart Saver Rx**			Tufts Medicare Preferred **HMO Saver Rx**			Tufts Medicare Preferred **HMO Basic Rx**		
Retail Cost Sharing—Preferred Pharmacy									
Tier	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply
Tier 1 (Preferred Generic)	$0	$0	$0	$0	$0	$0	$0	$0	$0
Tier 2 (Generic)	$2	$4	$6	$4	$8	$12	$4	$8	$12
Tier 3 (Preferred Brand)	$47 (Insulin: $35)	$94 (Insulin: $70)	$141 (Insulin: $105)	$47 (Insulin: $35)	$94 (Insulin: $70)	$141 (Insulin: $105)	$47 (Insulin: $35)	$94 (Insulin: $70)	$141 (Insulin: $105)
Tier 4 (Non-Preferred Drug)	$100 (Insulin: $35)	$200 (Insulin: $70)	$300 (Insulin: $105)	$100 (Insulin: $35)	$200 (Insulin: $70)	$300 (Insulin: $105)	$100 (Insulin: $35)	$200 (Insulin: $70)	$300 (Insulin: $105)
Tier 5 (Specialty Tier)	33% of the cost	N/A	N/A	29% of the cost	N/A	N/A	29% of the cost	N/A	N/A
Tier 6 (Vaccines)	$0	N/A	N/A	$0	N/A	N/A	$0	N/A	N/A

Tufts Medicare Preferred **HMO Value No Rx**	Tufts Medicare Preferred **HMO Value Rx**	Tufts Medicare Preferred **HMO Prime No Rx**	Tufts Medicare Preferred **HMO Prime Rx**	Tufts Medicare Preferred **HMO Prime Rx Plus**
This plan does not cover Part D prescription drugs	This plan does not have a deductible.	This plan does not cover Part D prescription drugs	This plan does not have a deductible	

Tufts Medicare Preferred **HMO Value No Rx**	Tufts Medicare Preferred **HMO Value Rx**	Tufts Medicare Preferred **HMO Prime No Rx**	Tufts Medicare Preferred **HMO Prime Rx**	Tufts Medicare Preferred **HMO Prime Rx Plus**
This plan does not cover Part D prescription drugs	You pay the following until your total yearly drug costs reach $5,030. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.	This plan does not cover Part D prescription drugs	You pay the following until your total yearly drug costs reach $5,030. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.	

Tufts Medicare Preferred **HMO Value Rx**			Tufts Medicare Preferred **HMO Prime Rx**			Tufts Medicare Preferred **HMO Prime Rx Plus**		
Retail Cost Sharing—Preferred Pharmacy								
30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply
$0	$0	$0	N/A	N/A	N/A	N/A	N/A	N/A
$4	$8	$12	N/A	N/A	N/A	N/A	N/A	N/A
$47 (Insulin: $35)	$94 (Insulin: $70)	$141 (Insulin: $105)	N/A	N/A	N/A	N/A	N/A	N/A
$100 (Insulin: $35)	$200 (Insulin: $70)	$300 (Insulin: $105)	N/A	N/A	N/A	N/A	N/A	N/A
33% of the cost	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
$0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Prescription Drug Benefits: Initial Coverage	Tufts Medicare Preferred **HMO Smart Saver Rx**			Tufts Medicare Preferred **HMO Saver Rx**			Tufts Medicare Preferred **HMO Basic Rx**		
Retail Cost Sharing—Non-Preferred Pharmacy									
Tier	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply
Tier 1 (Preferred Generic)	$14	$28	$42	$14	$28	$42	$14	$28	$42
Tier 2 (Generic)	$19	$38	$57	$19	$38	$57	$19	$38	$57
Tier 3 (Preferred Brand)	$47 (Insulin: $35)	$94 (Insulin: $70)	$141 (Insulin: $105)	$47 (Insulin: $35)	$94 (Insulin: $70)	$141 (Insulin: $105)	$47 (Insulin: $35)	$94 (Insulin: $70)	$141 (Insulin: $105)
Tier 4 (Non-Preferred Drug)	$100 (Insulin: $35)	$200 (Insulin: $70)	$300 (Insulin: $105)	$100 (Insulin: $35)	$200 (Insulin: $70)	$300 (Insulin: $105)	$100 (Insulin: $35)	$200 (Insulin: $70)	$300 (Insulin: $105)
Tier 5 (Specialty Tier)	33% of the cost	N/A	N/A	29% of the cost	N/A	N/A	29% of the cost	N/A	N/A
Tier 6 (Vaccines)	$0	N/A	N/A	$0	N/A	N/A	$0	N/A	N/A
Mail Order Cost Sharing									
Tier	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply
Tier 1 (Preferred Generic)	$0	$0	$0	$0	$0	$0	$0	$0	$0
Tier 2 (Generic)	$2	$4	$4	$4	$8	$8	$4	$8	$8
Tier 3 (Preferred Brand)	$47 (Insulin: $35)	$94 (Insulin: $70)	$94 (Insulin: $70	$47 (Insulin: $35)	$94 (Insulin: $70)	$94 (Insulin: $70)	$47 (Insulin: $35)	$94 (Insulin: $70)	$94 (Insulin: $70)
Tier 4 (Non-Preferred Drug)	$100 (Insulin: $35)	$200 (Insulin: $70)	$300 (Insulin: $105)	$100 (Insulin: $35)	$200 (Insulin: $70)	$300 (Insulin: $105)	$100 (Insulin: $35)	$200 (Insulin: $70)	$300 (Insulin: $105)
Tier 5 (Specialty Tier)	33% of the cost	N/A	N/A	29% of the cost	N/A	N/A	29% of the cost	N/A	N/A
Tier 6 (Vaccines)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	If you reside in a long-term care facility, you pay the same as at a preferred retail pharmacy. You may get drugs from an out-of-network pharmacy, but you may pay more than you pay at an in-network pharmacy. During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost.			If you reside in a long-term care facility, you pay the same as at a preferred retail pharmacy. You may get drugs from an out-of-network pharmacy, but you may pay more than you pay at an in-network pharmacy. During this stage, the plan pays its share of the cost of your Tier 1, Tier 2, Tier 6, and insulin drugs, and you pay your share of the cost. After you have met your annual $250 Tier 3, Tier 4, and Tier 5 deductible, the plan pays its share of the cost of your Tier 3, Tier 4, and Tier 5 drugs, and you pay your share.					

Tufts Medicare Preferred **HMO Value Rx**			Tufts Medicare Preferred **HMO Prime Rx**			Tufts Medicare Preferred **HMO Prime Rx Plus**		
Retail Cost Sharing—Non-Preferred Pharmacy								
30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply
$14	$28	$42	$4	$8	$12	$2	$4	$6
$19	$38	$57	$8	$16	$24	$4	$8	$12
$47 (Insulin: $35)	$94 (Insulin: $70)	$141 (Insulin: $105)	$45 (Insulin: $35)	$90 (Insulin: $70)	$135 (Insulin: $105)	$30	$60	$90
$100 (Insulin: $35)	$200 (Insulin: $70)	$300 (Insulin: $105)	$100 (Insulin: $35)	$200 (Insulin: $70)	$300 (Insulin: $105)	$80 (Insulin: $35)	$160 (Insulin: $70)	$240 (Insulin: $105)
33% of the cost	N/A	N/A	33% of the cost	N/A	N/A	33% of the cost	N/A	N/A
$0	N/A	N/A	$0	N/A	N/A	$0	N/A	N/A
Mail Order Cost Sharing								
30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply
$0	$0	$0	$4	$8	$8	$2	$4	$4
$4	$8	$8	$8	$16	$16	$4	$8	$8
$47 (Insulin: $35)	$94 (Insulin: $70)	$94 (Insulin: $70)	$45 (Insulin: $35)	$90 (Insulin: $70)	$90 (Insulin: $70)	$30	$60	$60
$100 (Insulin: $35)	$200 (Insulin: $70)	$300 (Insulin: $105)	$100 (Insulin: $35)	$200 (Insulin: $70)	$300 (Insulin: $105)	$80 (Insulin: $35)	$160 (Insulin: $70)	$240 (Insulin: $105)
33% of the cost	N/A	N/A	33% of the cost	N/A	N/A	33% of the cost	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
If you reside in a long-term care facility, you pay the same as at a preferred retail pharmacy. You may get drugs from an out-of-network pharmacy, but you may pay more than you pay at an in-network pharmacy. During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost.			If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy, but you may pay more than you pay at an in-network pharmacy. During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost.			If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy, but you may pay more than you pay at an in-network pharmacy. During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost.		

Prescription Drug Benefits: Coverage Gap	Tufts Medicare Preferred **HMO Smart Saver Rx**	Tufts Medicare Preferred **HMO Saver Rx**	Tufts Medicare Preferred **HMO Basic Rx**
	Most Medicare drug plans have a coverage gap (also called the "Donut Hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $5,030. After you enter the coverage gap, you pay $35 for a 30-day supply of covered insulin and nothing for covered Tier 6 vaccine drugs obtained through a retail pharmacy, 25% of the plan's cost for covered brand name drugs, and 25% of the plan's cost for covered generic drugs until your costs total $8,000, which is the end of the coverage gap. Not everyone will enter the coverage gap.		

Prescription Drug Benefits: Catastrophic Coverage	Tufts Medicare Preferred **HMO Smart Saver Rx**	Tufts Medicare Preferred **HMO Saver Rx**	Tufts Medicare Preferred **HMO Basic Rx**
	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $8,000, you pay nothing for covered Part D drugs and for excluded drugs that are covered under our enhanced benefit. During this payment stage, the plan pays the full cost for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.		

Tufts Medicare Preferred **HMO Value Rx**	Tufts Medicare Preferred **HMO Prime Rx**	Tufts Medicare Preferred **HMO Prime Rx Plus**
Most Medicare drug plans have a coverage gap (also called the "Donut Hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $5,030. After you enter the coverage gap, you pay $35 for a 30-day supply of covered insulin and nothing for covered Tier 6 vaccine drugs obtained through a retail pharmacy, 25% of the plan's cost for covered brand name drugs, and 25% of the plan's cost for covered generic drugs until your costs total $8,000, which is the end of the coverage gap. Not everyone will enter the coverage gap.		Most Medicare drug plans have a coverage gap (also called the "Donut Hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $5,030. After you enter the coverage gap, you pay nothing for covered Tier 6 vaccine drugs obtained through a retail pharmacy, and your cost share for Tier 3, Tier 4, and Tier 5 drugs will be 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs (note: you will pay $35 for a 30-day supply of covered Tier 3 and Tier 4 insulin). The table below shows your cost share for Tier 1 and Tier 2 drugs during this stage. You stay in this stage until your costs total $8,000, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Retail Cost Sharing			
Drug covered	30-day supply	60-day supply	90-day supply
Tier 1 (Preferred Generic)			
All	$2	$4	$6
Tier 2 (Generic)			
All	$4	$8	$12
Mail Order Cost Sharing			
Tier 1 (Preferred Generic)			
All	$2	$4	$4
Tier 2 (Generic)			
All	$4	$8	$8

Tufts Medicare Preferred **HMO Value Rx**	Tufts Medicare Preferred **HMO Prime Rx**	Tufts Medicare Preferred **HMO Prime Rx Plus**
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $8,000, you pay nothing for covered Part D drugs and for excluded drugs that are covered under our enhanced benefit. During this payment stage, the plan pays the full cost for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.		

OPTIONAL BENEFITS (You must pay an extra premium each month for these benefits)	Tufts Medicare Preferred **HMO Smart Saver Rx**	Tufts Medicare Preferred **HMO Saver Rx**	Tufts Medicare Preferred **HMO Basic No Rx**	Tufts Medicare Preferred **HMO Basic Rx**
Tufts Medicare Preferred Dental Option				
Benefits include	N/A	• Preventive services • Basic and Major services	• Preventive services • Basic and Major services	• Preventive services • Basic and Major services
Monthly premium	N/A	Additional $21.50 per month.	Additional $21.50 per month.	Additional $21.50 per month.
What You Should Know	N/A	You must keep paying your Medicare Part B premium.		
Deductible	N/A	This plan does not have a deductible.	This plan does not have a deductible.	This plan does not have a deductible.
The Tufts Medicare Preferred Dental Option offers the following benefits:	N/A	• Preventive services such as routine cleanings and oral exams covered at 100%. You pay $0. • Basic services such as fillings and simple extractions covered at 80%. You pay 20% of cost. • Major services such as dentures, bridges, and crowns covered at 50%. You pay 50% of cost.		
What You Should Know	N/A	Coverage is limited to providers within the Dominion PPO network. $1,000 calendar year maximum. No waiting period. Other benefit limits apply.		

Additional Benefits	Tufts Medicare Preferred **HMO Smart Saver Rx**	Tufts Medicare Preferred **HMO Saver Rx**	Tufts Medicare Preferred **HMO Basic No Rx**	Tufts Medicare Preferred **HMO Basic Rx**
Acupuncture				
Acupuncture services	$20 copay per visit	$20 copay per visit	$20 copay per visit	$20 copay per visit
What You Should Know	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. Before you receive services from a specialist, you must obtain a referral from your PCP. The plans will reimburse services rendered and billed directly by a licensed acupuncturist when there is a referral from your PCP. Additional acupuncture services are eligible for reimbursement under the annual Wellness Allowance benefit. See additional details under "Wellness Programs."			
Chiropractic Care				
Manual 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	$15 copay per visit	$15 copay per visit	$15 copay per visit
Initial evaluation (once per year)	$15 copay per visit	$15 copay per visit	$15 copay per visit	$15 copay per visit
What You Should Know	Before you receive services from a specialist, you must obtain a referral from your PCP.			

Tufts Medicare Preferred **HMO Value No Rx**	Tufts Medicare Preferred **HMO Value Rx**	Tufts Medicare Preferred **HMO Prime No Rx**	Tufts Medicare Preferred **HMO Prime Rx**	Tufts Medicare Preferred **HMO Prime Rx Plus**
Tufts Medicare Preferred Dental Option				
• Preventive services • Basic and Major services	• Preventive services • Basic and Major services	• Preventive services • Basic and Major services	• Preventive services • Basic and Major services	• Preventive services • Basic and Major services
Additional $21.50 per month.	Additional $21.50 per month.	Additional $31 per month.	Additional $31 per month.	Additional $31 per month.
You must keep paying your Medicare Part B premium and your monthly plan premium.				
This plan does not have a deductible.	This plan does not have a deductible.	This plan does not have a deductible.	This plan does not have a deductible.	This plan does not have a deductible.
• Preventive services such as routine cleanings and oral exams covered at 100%. You pay $0. • Basic services such as fillings and simple extractions covered at 80%. You pay 20% of cost. • Major services such as dentures, bridges, and crowns covered at 50%. You pay 50% of cost.				
Coverage is limited to providers within the Dominion PPO network. $1,000 calendar year maximum. No waiting period. Other benefit limits apply.				

Tufts Medicare Preferred **HMO Value No Rx**	Tufts Medicare Preferred **HMO Value Rx**	Tufts Medicare Preferred **HMO Prime No Rx**	Tufts Medicare Preferred **HMO Prime Rx**	Tufts Medicare Preferred **HMO Prime Rx Plus**
Acupuncture				
$20 copay per visit	$20 copay per visit	$20 copay per visit	$20 copay per visit	$20 copay per visit
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. Before you receive services from a specialist, you must obtain a referral from your PCP. The plans will reimburse services rendered and billed directly by a licensed acupuncturist when there is a referral from your PCP. Additional acupuncture services are eligible for reimbursement under the annual Wellness Allowance benefit. See additional details under "Wellness Programs."				
Chiropractic Care				
$15 copay per visit	$15 copay per visit	$15 copay per visit	$15 copay per visit	$15 copay per visit
$15 copay per visit	$15 copay per visit	$15 copay per visit	$15 copay per visit	$15 copay per visit
Before you receive services from a specialist, you must obtain a referral from your PCP.				

Additional Benefits	Tufts Medicare Preferred **HMO Smart Saver Rx**	Tufts Medicare Preferred **HMO Saver Rx**	Tufts Medicare Preferred **HMO Basic No Rx**	Tufts Medicare Preferred **HMO Basic Rx**
Foot Care (podiatry services)				
Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions	$45 copay per visit	$45 copay per visit	$40 copay per visit	$40 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	$0 copay	$0 copay	$0 copay	$0 copay
Home infusion therapy	$0 copay	$0 copay	$0 copay	$0 copay
What You Should Know	Prior authorization may be required for home infusion therapy.			
Hospice				
	Benefit provided by Medicare	Benefit provided by Medicare	Benefit provided by Medicare	Benefit provided by Medicare
What You Should Know	You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plans. Please contact us for more details.			
Medical Equipment/Supplies				
Durable medical equipment (e.g., wheelchairs, oxygen)	20% of the cost	20% of the cost	20% of the cost	20% of the cost
Prosthetic devices (e.g., braces, artificial limbs, etc.)	20% of the cost	20% of the cost	20% of the cost	20% of the cost
What You Should Know	Additional items covered by the plans: bathroom safety equipment for members who have a functional impairment when having the item will improve safety: • Raised toilet seat: 1 per member every five years • Bathroom grab bars: 2 per member every five years • Tub seat: 1 per member every five years The following additional items are covered by the plans: • Gradient compression stockings or surgical stockings: up to 2 pairs every 6 months • Mastectomy sleeves for members with upper limb lymphedema: up to 2 pairs every 6 months Prior authorization may be required.			
Wig allowance (for hair loss due to cancer treatment)	$500 per year	$500 per year	$500 per year	$500 per year
Diabetes services and supplies	$0 copay	$0 copay	$0 copay	$0 copay

Tufts Medicare Preferred **HMO Value No Rx**	Tufts Medicare Preferred **HMO Value Rx**	Tufts Medicare Preferred **HMO Prime No Rx**	Tufts Medicare Preferred **HMO Prime Rx**	Tufts Medicare Preferred **HMO Prime Rx Plus**
Foot Care (podiatry services)				
$25 copay per visit	$25 copay per visit	$15 copay per visit	$15 copay per visit	$15 copay per visit
Before you receive services from a specialist, you must obtain a referral from your PCP.				
Home Health Services				
$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Prior authorization may be required for home infusion therapy.				
Hospice				
Benefit provided by Medicare	Benefit provided by Medicare	Benefit provided by Medicare	Benefit provided by Medicare	Benefit provided by Medicare
You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plans. Please contact us for more details.				
Medical Equipment/Supplies				
10% of the cost	10% of the cost	10% of the cost	10% of the cost	10% of the cost
10% of the cost	10% of the cost	10% of the cost	10% of the cost	10% of the cost
Additional items covered by the plans: bathroom safety equipment for members who have a functional impairment when having the item will improve safety: • Raised toilet seat: 1 per member every five years • Bathroom grab bars: 2 per member every five years • Tub seat: 1 per member every five years The following additional items are covered by the plans: • Gradient compression stockings or surgical stockings: up to 2 pairs every 6 months • Mastectomy sleeves for members with upper limb lymphedema: up to 2 pairs every 6 months Prior authorization may be required.				
$500 per year	$500 per year	$500 per year	$500 per year	$500 per year
$0 copay	$0 copay	$0 copay	$0 copay	$0 copay

Additional Benefits	Tufts Medicare Preferred **HMO Smart Saver Rx**	Tufts Medicare Preferred **HMO Saver Rx**	Tufts Medicare Preferred **HMO Basic No Rx**	Tufts Medicare Preferred **HMO Basic Rx**
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 and blood glucose tests strips are limited to the OneTouch products manufactured by LifeScan, Inc. Please note that there is no preferred brand for lancets. Covered therapeutic Continuous Glucose Monitors (CGMs) include Dexcom and FreeStyle Libre products that are considered Durable Medical Equipment (DME) by Medicare. CGMs require prior authorization. Diabetic testing supplies, including test strips, lancets, glucose meters, and CGMs are also covered at participating retail or mail-order pharmacies.			
Outpatient Substance Abuse				
Group or individual therapy visit	$25 copay per visit	$25 copay per visit	$25 copay per visit	$25 copay per visit
Renal Dialysis				
	20% of the cost	20% of the cost	20% of the cost	20% of the cost
Telehealth/Telemedicine Services				
	Medicare-covered services plus additional telehealth services including PCP services, Specialist services, and more. You pay $0 for e-visits , virtual check-ins, and remote patient monitoring with a PCP or Specialist. For all other telehealth visits, the copay is the same as corresponding in-person visit copay. The same referral rules apply to additional telehealth services as corresponding in-person visits.			
Wellness Programs				
Over-the-counter (OTC) for Medicare items	$75 per calendar quarter	$110 per calendar quarter	N/A	N/A
What You Should Know	No rollover of unused calendar quarter balance. Items available at participating retailers and plan approved online stores.		N/A	
Weight Management program	The plans provide a $150 annual Weight Management allowance towards program fees for weight loss programs such as WeightWatchers® or a hospital-based weight loss program.			
Wellness Allowance	The plans provide a $350 annual Wellness Allowance toward health club memberships, nutritional counseling, acupuncture, or fitness classes like Pilates, tai chi, or aerobics, and wellness programs, including memory fitness activities.		The plans provide a $150 annual Wellness Allowance toward health club memberships, nutritional counseling, acupuncture, or fitness classes like Pilates, tai chi, or aerobics, and wellness programs, including memory fitness activities.	
SilverSneakers®	N/A		Applicable to residents of Worcester County only. SilverSneakers encourages physical activity by offering access to classes, exercise equipment, and other amenities. Members receive a basic fitness membership and access to over 14,000 participating locations. SilverSneakers offers different ways to get the activity you need to stay healthy.	

Tufts Medicare Preferred **HMO Value No Rx**	Tufts Medicare Preferred **HMO Value Rx**	Tufts Medicare Preferred **HMO Prime No Rx**	Tufts Medicare Preferred **HMO Prime Rx**	Tufts Medicare Preferred **HMO Prime Rx Plus**
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 and blood glucose tests strips are limited to the OneTouch products manufactured by LifeScan, Inc. Please note that there is no preferred brand for lancets. Covered therapeutic Continuous Glucose Monitors (CGMs) include Dexcom and FreeStyle Libre products that are considered Durable Medical Equipment (DME) by Medicare. CGMs require prior authorization. Diabetic testing supplies, including test strips, lancets, glucose meters, and CGMs are also covered at participating retail or mail-order pharmacies.				
Outpatient Substance Abuse				
$20 copay per visit	$20 copay per visit	$10 copay per visit	$10 copay per visit	$10 copay per visit
Renal Dialysis				
20% of the cost	20% of the cost	20% of the cost	20% of the cost	20% of the cost
Telehealth Services				
Medicare-covered services plus additional telehealth services including PCP services, Specialist services, and more. You pay $0 for e-visits, virtual check-ins, and remote patient monitoring with a PCP or Specialist. For all other telehealth visits, the copay is the same as corresponding in-person visit copay. The same referral rules apply to additional telehealth services as corresponding in-person visits.				
Wellness Programs				
N/A	N/A	N/A	N/A	N/A
N/A				
The plans provide a $150 annual Weight Management allowance towards program fees for weight loss programs such as WeightWatchers® or a hospital-based weight loss program.				
The plans provide a $150 annual Wellness Allowance toward health club memberships, nutritional counseling, acupuncture, or fitness classes like Pilates, tai chi, or aerobics, and wellness programs, including memory fitness activities.				
Applicable to residents of Worcester County only. SilverSneakers encourages physical activity by offering access to classes, exercise equipment, and other amenities. Members receive a basic fitness membership and access to over 14,000 participating locations. SilverSneakers offers different ways to get the activity you need to stay healthy.				N/A

Value Added Items and Services	
As a member of a Tufts Medicare Preferred HMO plan, you get exclusive discounts in addition to your plan benefits to help you lead a healthy lifestyle. Save on everything from health products to weight management, and a variety of wellness programs. This list of member discounts is effective January 1, 2024, and may change during the year. Please see our website at **www.thpmp.org/extras** for additional information.	
Fitness, Nutrition, and Weight Management	**Well Balanced Meal Delivery Program** Get a 15% discount on home-delivered meals through Independent Living Systems. Home-delivered meals offer a convenient and affordable way to recover from an illness, a surgical procedure, or to manage a chronic condition. **Nutritional Counseling** Get a 25% discount on visits with registered dieticians and licensed nutritionists. **The Dinner Daily** The Dinner Daily makes healthy, delicious dinners easy and affordable by providing you with weekly dinner plans customized for your food preferences, dietary needs, and the specials at your local grocery store. Eat better dinners, save money, and make dinners easy. Members receive 25% off any Dinner Daily subscription. Plus, your first two weeks are free to make it easy to try. **Daily Burn** Get a 30-day free trial followed by 25% off your monthly membership. Daily Burn offers over 2,500 curated videos and audio-based classes featuring a variety of programming including total-body workouts, barre, kickboxing, prenatal, meditation, strength, and Pilates training.
Independent Living	**Be Safer at Home** Get a discount on the installation and monthly fees of a Personal Emergency Response System (PERS). A PERS unit allows you to live the independent lifestyle you want by providing a resource that is always there to respond to emergency calls. **LifeCycle Transitions** Save 20% on a variety of services that help members with chronic health problems stay well at home or transition to a new location. **Home Instead Senior Care** Home Instead provides high quality, trusted home care to help seniors stay in their homes. Receive a one-time $100.00 credit toward charges for services at participating offices. Tufts Health Plan members also receive a free home safety inspection once you have contracted for services with Home Instead Senior Care.
Personal Growth and Development	**Cambridge Health Alliance Center for Mindfulness and Compassion** Save 15% on Cambridge Health Alliance Center for Mindfulness and Compassion's eight-week Mindfulness-Based Stress Reduction and Mindful Self-Compassion courses. Experience mindfulness and compassion training to reduce stress and improve your overall well-being. **Ompractice** With Ompractice, you can access live, online yoga and meditation classes led by an instructor to practice yoga from the comfort and privacy of your own home. Ompractice utilizes two-way video, so you can participate in group classes and receive feedback and support from your teacher. Sign up for Ompractice for $14.99/month or $129.00 for an annual subscription (a 40% discount off the monthly plan). Additionally, members who have an Annual Wellness Benefit may use their Annual Wellness Allowance to cover the cost of membership.
Health and Wellness Discounts	**Massage Therapy** Get a 25% discount on the usual and customary fee, or pay $15 per 15 minutes of massage therapy, whichever is less. **Acupuncture** Receive a 25% discount on the usual and customary fee. **Laser Vision Correction** Get 15% off the retail price, or 5% off the promotional price of LASIK and PRK laser vision correction.

TUFTS Health Plan

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OMB# 0938-1421

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-701-9000 (HMO)/1-866-623-0172 (PPO). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-701-9000 (HMO)/1-866-623-0172 (PPO). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-701-9000 (HMO)/1-866-623-0172 (PPO)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-701-9000 (HMO)/1-866-623-0172 (PPO)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-701-9000 (HMO)/1-866-623-0172 (PPO). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-701-9000 (HMO)/1-866-623-0172 (PPO). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-701-9000 (HMO)/1-866-623-0172 (PPO). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Form CMS-10802
(Expires 12/31/25)

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-701-9000 (HMO)/1-866-623-0172 (PPO)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-701-9000 (HMO)/1-866-623-0172 (PPO). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على **1-800-701-9000 (HMO)/1-866-623-0172 (PPO)** سيقوم شخص ما يتحدث العربية . بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-701-9000 (HMO)/1-866-623-0172 (PPO). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-701-9000 (HMO)/1-866-623-0172 (PPO). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-701-9000 (HMO)/1-866-623-0172 (PPO). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-701-9000 (HMO)/1-866-623-0172 (PPO). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-701-9000 (HMO)/1-866-623-0172 (PPO)にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

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Form CMS-10802
(Expires 12/31/25)

Questions

Visit us at **www.thpmp.org,** or call 1-877-409-3499 (TTY: 711).

TUFTS Health Plan

1 Wellness Way
Canton, MA 02021