Tufts Medicare Preferred Access (PPO) offered by Tufts Associated Health Maintenance Organization (Tufts Health Plan)

Annual Notice of Changes for 2025

You are currently enrolled as a member of Tufts Medicare Preferred Access PPO. Next year, there will be changes to the plan's costs and benefits. ***Please see page 5 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules, please review the *Evidence of Coverage*, which is located on our website at www.thpmp.org. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. **ASK:** Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- Review the changes to medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including coverage restrictions and cost sharing.
- Think about how much you will spend on premiums, deductibles, and cost sharing.
- Check the changes in the 2025 "Drug List" to make sure the drugs you currently take are still covered.
- Compare the 2024 and 2025 plan information to see if any of these drugs are moving to a different cost-sharing tier or will be subject to different restrictions, such as prior authorization, step therapy, or a quantity limit, for 2025.

☐ Check to see if your primary care doctors, specialists, hospitals, and other providers, including pharmacies, will be in our network next year.

☐ Check if you qualify for help paying for prescription drugs. People with limited incomes may qualify for "Extra Help" from Medicare.

☐ Think about whether you are happy with our plan.

2. **COMPARE:** Learn about other plan choices

- ☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at www.medicare.gov/plan-compare or review the list in the back of your *Medicare & You 2025* handbook. For additional support, contact your State Health Insurance Assistance Program (SHIP) to speak with a trained counselor.
- ☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE:** Decide whether you want to change your plan

- If you don't join another plan by December 7, 2024, you will stay in Tufts Medicare Preferred Access.
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2025.** This will end your enrollment with Tufts Medicare Preferred Access.
- If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Member Services number at 1-866-623-0172 for additional information. (TTY users should call 711.) Hours are 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31 and Monday – Friday from April 1 to September 30. This call is free.
- This information is available in different formats, including large print.
- **Coverage under this plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Tufts Medicare Preferred Access

- Tufts Medicare Preferred Access is a Medicare Advantage PPO plan. Enrollment in Tufts Medicare Preferred Access depends on contract renewal.

- When this document says “we,” “us,” or “our,” it means Tufts Associated Health Maintenance Organization (Tufts Health Plan). When it says “plan” or “our plan,” it means Tufts Medicare Preferred Access.

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Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for Tufts Medicare Preferred Access in several important areas. **Please note this is only a summary of costs**.

Cost	2024 (this year)	2025 (next year)
Monthly plan premium* * Your premium may be higher than this amount. See Section 1.1 for details.	$0	$0
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered services. (See Section 1.2 for details.)	From network providers: $5,600 From network and out-of-network providers combined: $9,550	From network providers: $5,400 From network and out-of-network providers combined: $9,500
Doctor office visits	**In-Network:** Primary care visits: $0 per visit Specialist visits: $45 per visit **Out-of-Network:** Primary care visits: $0 per visit Specialist visits: $45 per visit	**In-Network:** Primary care visits: $0 per visit Specialist visits: $40 per visit **Out-of-Network:** Primary care visits: $0 per visit Specialist visits: $40 per visit
Inpatient hospital stays	**In-Network:** $400 per day for days 1-5 and $0 after day 5 for Medicare-covered services received in a general acute care, rehabilitation, or long-term acute care hospital.	**In-Network:** $400 per day for days 1-5 and $0 after day 5 for Medicare-covered services received in a general acute care, rehabilitation, or long-term acute care hospital.

Cost	2024 (this year)	2025 (next year)
	$400 per day for days 1-4 and $0 after day 4 for Medicare-covered services received in a psychiatric hospital. **Out-of-Network:** 40% coinsurance for Medicare-covered services received in a general acute care, rehabilitation, or long-term acute care or psychiatric hospital.	$400 per day for days 1-4 and $0 after day 4 for Medicare-covered services received in a psychiatric hospital. **Out-of-Network:** 45% coinsurance for Medicare-covered services received in a general acute care, rehabilitation, or long-term acute care or psychiatric hospital.

Cost	2024 (this year)	2025 (next year)
Part D prescription drug coverage (See Section 1.5 for details.) Tier 1 and Tier 2 drugs include enhanced coverage of certain drugs such as select erectile dysfunction (ED) drugs, vitamins and minerals, and cough/cold products.	Deductible: $0 Copayment/ Coinsurance during the Initial Coverage Stage: **Drug Tier 1:** $0-$14 per prescription at a retail pharmacy for a 30-day supply. $0-$28 per prescription at a retail pharmacy for up to a 60-day supply. $0-$42 per prescription at a retail pharmacy for up to a 90-day supply. $0 per prescription at a mail order pharmacy for a 30-day supply. $0 per prescription at a mail order pharmacy for up to a 60-day supply. $0 per prescription at a mail order pharmacy for up to a 90-day supply.	Deductible: $0 Copayment/ Coinsurance during the Initial Coverage Stage: **Drug Tier 1:** $0-$14 per prescription at a retail pharmacy for a 30-day supply. $0-$28 per prescription at a retail pharmacy for up to a 60-day supply. $0-$42 per prescription at a retail pharmacy for up to a 90-day supply. $0 per prescription at a mail order pharmacy for a 30-day supply. $0 per prescription at a mail order pharmacy for up to a 60-day supply. $0 per prescription at a mail order pharmacy for up to a 90-day supply.

Cost	2024 (this year)	2025 (next year)
	Drug Tier 2: $4-$19 per prescription at a retail pharmacy for a 30-day supply. $8-$38 per prescription at a retail pharmacy for up to a 60-day supply. $12-$57 per prescription at a retail pharmacy for up to a 90-day supply. $4 per prescription at a mail order pharmacy for a 30-day supply. $8 per prescription at a mail order pharmacy for up to a 60-day supply. $8 per prescription at a mail order pharmacy for up to a 90-day supply. **Drug Tier 3:** $47 per prescription at a retail pharmacy for a 30-day supply. You pay $35 per month supply of each covered insulin product on this tier.	**Drug Tier 2:** $8-$20 per prescription at a retail pharmacy for a 30-day supply. $16-$40 per prescription at a retail pharmacy for up to a 60-day supply. $24-$60 per prescription at a retail pharmacy for up to a 90-day supply. $8 per prescription at a mail order pharmacy for a 30-day supply. $16 per prescription at a mail order pharmacy for up to a 60-day supply. $16 per prescription at a mail order pharmacy for up to a 90-day supply. **Drug Tier 3:** 23% coinsurance per prescription at a retail pharmacy for a 30-day supply. You pay $35 per month supply of each covered insulin product on this tier.

Cost	2024 (this year)	2025 (next year)
	$94 per prescription at a retail pharmacy for up to a 60-day supply. You pay $70 for a 60-day supply of each covered insulin product on this tier. $141 per prescription at a retail pharmacy for up to a 90-day supply. You pay $105 for a 90-day supply of each covered insulin product on this tier. $47 per prescription at a mail order pharmacy for a 30-day supply. You pay $35 per month supply of each covered insulin product on this tier. $94 per prescription at a mail order pharmacy for up to a 60-day supply. You pay $70 for a 60-day supply of each covered insulin product on this tier.	23% coinsurance per prescription at a retail pharmacy for up to a 60-day supply. You pay $70 for a 60-day supply of each covered insulin product on this tier. 23% coinsurance per prescription at a retail pharmacy for up to a 90-day supply. You pay $105 for a 90-day supply of each covered insulin product on this tier. 23% coinsurance per prescription at a mail order pharmacy for a 30-day supply. You pay $35 per month supply of each covered insulin product on this tier. 23% coinsurance per prescription at a mail order pharmacy for up to a 60-day supply. You pay $70 for a 60-day supply of each covered insulin product on this tier.

Cost	2024 (this year)	2025 (next year)
	$94 per prescription at a mail order pharmacy for up to a 90-day supply. You pay $70 for a 90-day supply of each covered insulin product on this tier.	23% coinsurance per prescription at a mail order pharmacy for up to a 90-day supply. You pay $70 for a 90-day supply of each covered insulin product on this tier.
	Drug Tier 4: $100 per prescription at a retail pharmacy for a 30-day supply. You pay $35 per month supply of each covered insulin product on this tier.	**Drug Tier 4:** 50% coinsurance per prescription at a retail pharmacy for a 30-day supply. You pay $35 per month supply of each covered insulin product on this tier.
	$200 per prescription at a retail pharmacy for up to a 60-day supply. You pay $70 for a 60-day supply of each covered insulin product on this tier.	50% per prescription at a retail pharmacy for up to a 60-day supply. You pay $70 for a 60-day supply of each covered insulin product on this tier.
	$300 per prescription at a retail pharmacy for up to a 90-day supply. You pay $105 for a 90-day supply of each covered insulin product on this tier.	50% per prescription at a retail pharmacy for up to a 90-day supply. You pay $105 for a 90-day supply of each covered insulin product on this tier.

Cost	2024 (this year)	2025 (next year)
	$100 per prescription at a mail order pharmacy for a 30-day supply. You pay $35 per month supply of each covered insulin product on this tier. $200 per prescription at a mail order pharmacy for up to a 60-day supply. You pay $70 for a 60-day supply of each covered insulin product on this tier. $300 per prescription at a mail order pharmacy for up to a 90-day supply. You pay $105 for a 90-day supply of each covered insulin product on this tier. **Drug Tier 5:** 33% coinsurance per prescription at a retail or mail order pharmacy for a 30-day supply. 60-day and 90-day supplies are not covered for drugs on Tier 5.	50% coinsurance per prescription at a mail order pharmacy for a 30-day supply. You pay $35 per month supply of each covered insulin product on this tier. 50% coinsurance per prescription at a mail order pharmacy for up to a 60-day supply. You pay $70 for a 60-day supply of each covered insulin product on this tier. 50% coinsurance per prescription at a mail order pharmacy for up to a 90-day supply. You pay $105 for a 90-day supply of each covered insulin product on this tier. **Drug Tier 5:** 33% coinsurance per prescription at a retail or mail order pharmacy for a 30-day supply. 60-day and 90-day supplies are not covered for drugs on Tier 5.

Cost	2024 (this year)	2025 (next year)
	Drug Tier 6: $0 per Tier 6 vaccine. Not applicable at Mail Order. Catastrophic Coverage: • 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. You pay nothing.	**Drug Tier 6:** $0 per Tier 6 vaccine. Not applicable at Mail Order. Catastrophic Coverage: • During this payment stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2024 (this year)	2025 (next year)
Monthly premium There is no change to the plan premium for the upcoming benefit year. (You must also continue to pay your Medicare Part B premium.)	$0	$0

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amounts

Medicare requires all health plans to limit how much you pay out-of-pocket for the year. These limits are called the maximum out-of-pocket amounts. Once you reach this amount, you generally pay nothing for covered services for the rest of the year.

Cost	2024 (this year)	2025 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays) from network providers count toward your in-network maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$5,600	$5,400 Once you have paid $5,400 out-of-pocket for covered services, you will pay nothing for your covered services from network providers for the rest of the calendar year.

Cost	2024 (this year)	2025 (next year)
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your costs for outpatient prescription drugs do not count toward your maximum out-of-pocket amount for medical services.	$9,550	$9,500 Once you have paid $9,500 out-of-pocket for covered services, you will pay nothing for your covered services from network or out-of-network providers for the rest of the calendar year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

Updated directories are located on our website at www.thpmp.org. You may also call Member Services for updated provider and/or pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are changes to our network of providers for next year. Please review the ***2025 Provider Directory*** at **www.thpmp.org** to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.

There are changes to our network of pharmacies for next year. Please review the ***2025 Pharmacy Directory*** at **www.thpmp.org** to see which pharmacies are in our network.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Member Services so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2024 (this year)	2025 (next year)
Abdominal aortic aneurysm screening	**In-Network:** There is no coinsurance, copayment, or deductible for members eligible for this preventive screening. **Out-of-Network:** You pay 40% coinsurance for this Medicare-covered preventive screening.	**In-Network:** There is no coinsurance, copayment, or deductible for members eligible for this preventive screening. **Out-of-Network:** You pay 45% coinsurance for this Medicare-covered preventive screening. Please refer to your *Evidence of Coverage* for more information.
Annual physical exam	**In-Network:** You pay $0 for an annual physical exam. **Out-of-Network:** You pay 40% coinsurance for an annual physical exam.	**In-Network and Out-of-Network:** You pay $0 for an annual physical exam. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Annual wellness visit	**In-Network:** There is no coinsurance, copayment, or deductible for the annual wellness visit. **Out-of-Network:** You pay 40% coinsurance for the annual wellness visit.	**In-Network and Out-of-Network:** There is no coinsurance, copayment, or deductible for the annual wellness visit. Please refer to your *Evidence of Coverage* for more information.
Blood Services	**In-Network:** You pay $0 for Medicare-covered blood services. **Out-of-Network:** You pay 40% coinsurance for Medicare-covered blood services.	**In-Network:** You pay $0 for Medicare-covered blood services. **Out-of-Network:** You pay 45% coinsurance for Medicare-covered blood services. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Bone mass measurement	**In-Network:** There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement. **Out-of-Network:** You pay 40% coinsurance for Medicare-covered bone mass measurement.	**In-Network:** There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement. **Out-of-Network:** You pay 45% coinsurance for Medicare-covered bone mass measurement. Please refer to your *Evidence of Coverage* for more information.
Breast cancer screening (mammograms)	**In-Network:** There is no coinsurance, copayment, or deductible for covered screening mammograms. **Out-of-Network:** You pay 40% coinsurance for covered screening mammograms.	**In-Network:** There is no coinsurance, copayment, or deductible for covered screening mammograms. **Out-of-Network:** You pay 45% coinsurance for covered screening mammograms. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Cardiac rehabilitation services	**In-Network:** You pay $0 for Medicare-covered services. **Out-of-Network:** You pay 40% coinsurance for Medicare-covered services.	**In-Network:** You pay $0 for Medicare-covered services. **Out-of-Network:** You pay 45% coinsurance for Medicare-covered services. Except in an emergency, prior authorization may be required before you receive this service in-network. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Cardiovascular disease testing	**In-Network:** There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years. **Out-of-Network:** You pay 40% coinsurance for cardiovascular disease testing that is covered once every 5 years.	**In-Network and Out-of-Network:** There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)	**In-Network:** There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit. **Out-of-Network:** You pay 40% coinsurance for the intensive behavioral therapy cardiovascular disease preventive benefit.	**In-Network and Out-of-Network:** There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Cervical and vaginal cancer screening	**In-Network:** There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams. **Out-of-Network:** You pay 40% coinsurance for Medicare-covered preventive Pap and pelvic exams.	**In-Network and Out-of-Network:** There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Chiropractic services - Manual Manipulation of the Spine to Correct Subluxation	**In-Network:** You pay $15 for each Medicare-covered visit. **Out-of-Network:** You pay 40% coinsurance for each Medicare-covered visit.	**In-Network:** You pay $15 for each Medicare-covered visit. **Out-of-Network:** You pay 45% coinsurance for each Medicare-covered visit. Except in an emergency, prior authorization may be required before you receive this service in-network. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Chiropractic services - initial evaluation	**In-Network:** You pay $15 for the initial chiropractic evaluation covered once a calendar year. **Out-of-Network:** You pay 40% coinsurance for each Medicare-covered visit.	**In-Network:** You pay $15 for the initial chiropractic evaluation covered once a calendar year. **Out-of-Network:** You pay 45% coinsurance for each Medicare-covered visit. Except in an emergency, prior authorization may be required before you receive this service in-network. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Colorectal cancer screening	**In-Network:** There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam, including barium enemas. **Out-of-Network:** You pay 40% coinsurance for a Medicare-covered colorectal cancer screening exam, including barium enemas.	**In-Network:** There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam, including barium enemas. **Out-of-Network:** You pay 45% coinsurance for a Medicare-covered colorectal cancer screening exam, including barium enemas. Please refer to your *Evidence of Coverage* for more information.
Dental (Medicare covered)	**In-Network and Out-of-Network:** You pay $45 per visit for Medicare-covered dental services.	**In-Network and Out-of-Network:** You pay $40 per visit for Medicare-covered dental services. Except in an emergency, prior authorization may be required before you receive this service in-network. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Depression screening	**In-Network:** There is no coinsurance, copayment, or deductible for an annual depression screening visit. **Out-of-Network:** You pay 40% coinsurance for an annual depression screening visit.	**In-Network and Out-of-Network:** There is no coinsurance, copayment, or deductible for an annual depression screening visit. Please refer to your *Evidence of Coverage* for more information.
Diabetes screening	**In-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests. **Out-of-Network:** You pay 40% coinsurance for the Medicare-covered diabetes screening tests.	**In-Network and Out-of-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Diabetes self-management training	**In-Network:** You pay $0 for diabetes self-management training. **Out-of-Network:** You pay 40% coinsurance for diabetes self-management training.	**In-Network:** You pay $0 for diabetes self-management training. **Out-of-Network:** You pay 45% coinsurance for diabetes self-management training. Please refer to your *Evidence of Coverage* for more information.
DME - Medical supplies	**In-Network:** You pay 20% coinsurance for Medicare-covered medical supplies. **Out-of-Network:** You pay 50% coinsurance for Medicare-covered medical supplies.	**In-Network:** You pay $0 for Medicare-covered medical supplies provided as part of an office visit; otherwise you pay 20% coinsurance. **Out-of-Network:** You pay $0 for Medicare-covered medical supplies provided as part of an office visit; otherwise you pay 50% coinsurance coinsurance. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Emergency care	**In-Network and Out-of-Network:** You pay $90 for each covered emergency room (ER) visit. You will still pay this ER copay amount if you are held for observation. You do not pay this ER amount if you are admitted as an inpatient to the hospital within 24 hours for the same condition (refer to **Inpatient Hospital Care** section in your *Evidence of Coverage* for hospital cost-share that applies instead).	**In-Network and Out-of-Network:** You pay $125 for each covered emergency room (ER) visit. If you are held for observation following the ER visit, the ER copay will be waived and you will pay the Observation copay (refer to **Outpatient hospital observation** section of your *Evidence of Coverage* for outpatient hospital observation cost-share that applies instead). You do not pay the ER or Observation copay amount if you are admitted as an inpatient to the hospital within one day for the same condition (refer to **Inpatient Hospital Care** section in your *Evidence of Coverage* for hospital cost-share that applies instead). Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Hearing - Diagnostic Hearing Exam	**In-Network and Out-of-Network:** You pay $45 per visit for Medicare-covered diagnostic hearing exam.	**In-Network and Out-of-Network:** You pay $40 per visit for Medicare-covered diagnostic hearing exam. Please refer to your *Evidence of Coverage* for more information.
Hearing - Routine Hearing Exam	**In-Network:** You pay $0 for an annual routine hearing test. **Out-of-Network:** You pay $45 per visit for an annual routine hearing test.	**In-Network:** You pay $0 for an annual routine hearing test. **Out-of-Network:** You pay $40 per visit for an annual routine hearing test. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Hearing Aid Fitting	**In-Network:** You pay $0 for hearing aid fitting evaluations received through Hearing Care Solutions. **Out-of-Network:** You pay 40% coinsurance for hearing aid fitting evaluations by providers other than Hearing Care Solutions.	**In-Network:** You pay $0 for hearing aid fitting evaluations received through Hearing Care Solutions. **Out-of-Network:** You pay 45% coinsurance for hearing aid fitting evaluations by providers other than Hearing Care Solutions. Please refer to your *Evidence of Coverage* for more information.
HIV screening	**In-Network:** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening. **Out-of-Network:** You pay 40% coinsurance for Medicare-covered preventive HIV screening.	**In-Network:** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening. **Out-of-Network:** You pay 45% coinsurance for Medicare-covered preventive HIV screening. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Home health agency care	**In-Network:** You pay $0 for Medicare-covered home health care services. **Out-of-Network:** You pay 50% coinsurance for Medicare-covered home health care services.	**In-Network:** You pay $0 for Medicare-covered home health care services. **Out-of-Network:** You pay 50% coinsurance for Medicare-covered home health care services. Except in an emergency, prior authorization may be required before you receive this service in-network. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Inpatient hospital care	**In-Network:** Each time you are admitted to an acute care hospital, you pay $400 per day for days 1-5 and $0 after day 5. **Out-of-Network:** Each time you are admitted to an acute care hospital, you pay 40% coinsurance per stay. Except in an emergency, prior authorization may be required before you receive this service in-network.	**In-Network:** Each time you are admitted to an acute care hospital, you pay $400 per day for days 1-5 and $0 after day 5. **Out-of-Network:** Each time you are admitted to an acute care hospital, you pay 45% coinsurance per stay. Except in an emergency, prior authorization may be required before you receive this service in-network. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Inpatient rehabilitation hospital	**In-Network:** Each time you are admitted to an acute rehabilitation or long-term acute care hospital, you pay $400 per day for days 1-5 and $0 after day 5 for up to 90 days in a benefit period for Medicare-covered services. **Out-of-Network:** Each time you are admitted to an acute rehabilitation or long-term acute care hospital, you pay 40% coinsurance per stay for up to 90 days in a benefit period for Medicare covered services. Except in an emergency, prior authorization may be required before you receive this service in-network.	**In-Network:** Each time you are admitted to an acute rehabilitation or long-term acute care hospital, you pay $400 per day for days 1-5 and $0 after day 5 for up to 90 days in a benefit period for Medicare-covered services. **Out-of-Network:** Each time you are admitted to an acute rehabilitation or long-term acute care hospital, you pay 45% coinsurance for up to 90 days in a benefit period for Medicare-covered services. Except in an emergency, prior authorization may be required before you receive this service in-network. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Inpatient services in a psychiatric hospital	**In-Network:** Each time you are admitted to a psychiatric hospital for covered services, you pay $400 per day for days 1-4 and $0 after day 4. **Out-of-Network:** Each time you are admitted to a psychiatric hospital for covered services, you pay 40% coinsurance per stay.	**In-Network:** Each time you are admitted to a psychiatric hospital for covered services, you pay $400 per day for days 1-4 and $0 after day 4. **Out-of-Network:** Each time you are admitted to a psychiatric hospital for covered services, you pay 45% coinsurance per stay. Please refer to your *Evidence of Coverage* for more information.
Inpatient stay: Covered services during a non-covered inpatient stay	**In-Network:** You pay $0 for Medicare-covered services provided in the hospital or skilled nursing facility (SNF). **Out-of-Network:** You pay 40% coinsurance for Medicare-covered services provided in the hospital or skilled nursing facility (SNF).	**In-Network:** You pay $0 for Medicare-covered services provided in the hospital or skilled nursing facility (SNF). **Out-of-Network:** You pay 45% coinsurance for Medicare-covered services provided in the hospital or skilled nursing facility (SNF). Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
MDPP - Medicare Diabetes Prevention Program	**In-Network:** There is no coinsurance, copayment, or deductible for the MDPP benefit. **Out-of-Network:** You pay 40% coinsurance for the MDPP benefit.	**In-Network:** There is no coinsurance, copayment, or deductible for the MDPP benefit. **Out-of-Network:** You pay 45% coinsurance for the MDPP benefit. Please refer to your *Evidence of Coverage* for more information.
Medical nutrition therapy	**In-Network:** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services. **Out-of-Network:** You pay 40% coinsurance for Medicare-covered medical nutrition therapy services.	**In-Network:** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services. **Out-of-Network:** You pay 45% coinsurance for Medicare-covered medical nutrition therapy services. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Medicare Part B prescription drugs	**In-Network:** You pay up to 20% coinsurance for Medicare Part B chemotherapy prescription drugs. You pay $35 per month for covered insulin when used in an insulin pump. You pay up to 20% coinsurance for all other Medicare Part B non-chemotherapy prescription drugs. **Out-of-Network:** You pay 40% coinsurance for Medicare Part B chemotherapy prescription drugs. You pay $35 per month for covered insulin when used in an insulin pump. You pay 40% coinsurance for all other Medicare Part B non-chemotherapy prescription drugs.	**In-Network:** You pay up to 20% coinsurance for Medicare Part B chemotherapy prescription drugs. You pay $35 per month for covered insulin when used in an insulin pump. You pay up to 20% coinsurance for all other Medicare Part B non-chemotherapy prescription drugs. **Out-of-Network:** You pay 45% coinsurance for Medicare Part B chemotherapy prescription drugs. You pay $35 per month for covered insulin when used in an insulin pump. You pay 45% coinsurance for all other Medicare Part B non-chemotherapy prescription drugs.

Cost	2024 (this year)	2025 (next year)
	Part B drugs may be subject to Step Therapy requirements. Except in an emergency, prior authorization may be required before you receive this service in-network.	Part B drugs may be subject to Step Therapy requirements. Except in an emergency, prior authorization may be required before you receive this service in-network. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Non-ambulance transportation	Non-ambulance transportation is not covered.	You pay $0 for non-ambulance transportation by plan-approved transportation vendor from a hospital to a skilled nursing facility or to your home when ordered by the discharging hospital. Please refer to your *Evidence of Coverage* for more information.
Obesity screening and therapy to promote sustained weight loss	**In-Network:** There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy. **Out-of-Network:** You pay 40% coinsurance for preventive obesity screening and therapy.	**In-Network and Out-of-Network:** There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Office visit - Specialist	**In-Network and Out-of-Network:** You pay $45 per visit for each covered in-person or telehealth visit or consultation in an outpatient location with a specialist.	**In-Network and Out-of-Network:** You pay $40 per visit for each covered in-person or telehealth visit or consultation in an outpatient location with a specialist. Please refer to your *Evidence of Coverage* for more information.
Opioid treatment program services	**In-Network:** You pay $25 per encounter for Medicare-covered Opioid treatment program services. **Out-of-Network:** You pay 40% coinsurance for Medicare-covered Opioid treatment program services.	**In-Network:** You pay $25 per encounter for Medicare-covered Opioid treatment program services. **Out-of-Network:** You pay 45% coinsurance for Medicare-covered Opioid treatment program services. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Outpatient diagnostic labs	**In-Network:** You pay $0 for Medicare-covered laboratory tests. **Out-of-Network:** You pay 40% coinsurance for Medicare-covered laboratory tests. Except in an emergency, prior authorization may be required before you receive this service in-network.	**In-Network:** You pay $0 for Medicare-covered laboratory tests. **Out-of-Network:** You pay 45% coinsurance for Medicare-covered laboratory tests. Except in an emergency, prior authorization may be required before you receive this service in-network. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Outpatient diagnostic radiology services	**In-Network:** You pay $100 per day for a Medicare-covered Ultrasound. You pay $200 per day for other Medicare-covered diagnostic radiology services that are not Ultrasounds. **Out-of-Network:** You pay 40% coinsurance for Medicare-covered diagnostic radiology services. Except in an emergency, prior authorization may be required before you receive this service in-network.	**In-Network:** You pay $100 per day for a Medicare-covered Ultrasound. You pay $140 per day for other Medicare-covered diagnostic radiology services that are not Ultrasounds. **Out-of-Network:** You pay 45% coinsurance for Medicare-covered diagnostic radiology services. Except in an emergency, prior authorization may be required before you receive this service in-network. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Outpatient diagnostic tests	**In-Network:** You pay $30 per day for Medicare-covered outpatient diagnostic tests. **Out-of-Network:** You pay 40% coinsurance for Medicare-covered outpatient diagnostic tests. Except in an emergency, prior authorization may be required before you receive this service in-network.	**In-Network:** You pay $30 per day for Medicare-covered outpatient diagnostic tests. **Out-of-Network:** You pay 45% coinsurance for Medicare-covered outpatient diagnostic tests. Except in an emergency, prior authorization may be required before you receive this service in-network. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Outpatient therapeutic radiology	**In-Network:** You pay $60 per day for Medicare-covered radiation therapy. **Out-of-Network:** You pay 40% coinsurance for Medicare-covered radiation therapy. Except in an emergency, prior authorization may be required before you receive this service in-network.	**In-Network:** You pay $60 per day for Medicare-covered radiation therapy. **Out-of-Network:** You pay 45% coinsurance for Medicare-covered radiation therapy. Except in an emergency, prior authorization may be required before you receive this service in-network. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Outpatient diagnostic X-rays	**In-Network:** You pay $30 per day for Medicare-covered X-rays. **Out-of-Network:** You pay 40% coinsurance for Medicare-covered X-rays. Except in an emergency, prior authorization may be required before you receive this service in-network.	**In-Network:** You pay $30 per day for Medicare-covered X-rays. **Out-of-Network:** You pay 45% coinsurance for Medicare-covered X-rays. Except in an emergency, prior authorization may be required before you receive this service in-network. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Outpatient hospital observation	**In-Network:** You pay $0 per observation stay. **Out-of-Network:** You pay 40% coinsurance for observation stays. Additional cost-share may apply if you receive other outpatient services while held in observation.	**In-Network:** You pay $390 per observation stay. **Out-of-Network:** You pay 45% coinsurance for observation stays. Additional cost-share may apply if you receive other outpatient services while held in observation. You do not pay the outpatient hospital observation cost-share if you are admitted as an inpatient to the hospital within one day for the same condition (refer to **Inpatient Hospital Care** section in your *Evidence of Coverage* for hospital cost-share that applies instead). Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Outpatient hospital services	**In-Network and Out-of-Network:** See the following sections in this chart for applicable details and changes: **Observation services**, see "Outpatient hospital observation" in this chart. **Outpatient surgery**, see "Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers" in this chart. **Laboratory tests**, see "Outpatient diagnostic labs" in this chart. **Diagnostic tests**, see "Outpatient diagnostic tests" in this chart. **X-rays**, see "Outpatient diagnostic X-rays" in this chart.	**In-Network and Out-of-Network:** See the following sections in this chart for applicable details and changes: **Observation services**, see "Outpatient hospital observation" in this chart. **Outpatient surgery**, see "Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers" in this chart. **Laboratory tests**, see "Outpatient diagnostic labs" in this chart. **Diagnostic tests**, see "Outpatient diagnostic tests" in this chart. **X-rays**, see "Outpatient diagnostic X-rays" in this chart.

Cost	2024 (this year)	2025 (next year)
	Radiological services, see "Outpatient diagnostic radiology services" and "Outpatient therapeutic radiology" in this chart. **Mental health care and Partial hospitalization**, see "Outpatient mental health care" and "Partial hospitalization services" in this chart. **Chemical dependency care**, see "Outpatient substance abuse services" in this chart. **Drugs and biologicals that you can't give yourself**, see "Medicare Part B prescription drugs" in this chart.	**Radiological services**, see "Outpatient diagnostic radiology services" and "Outpatient therapeutic radiology" in this chart. **Mental health care and Partial hospitalization**, see "Outpatient mental health care" and "Partial hospitalization services" in this chart. **Chemical dependency care**, see "Outpatient substance use disorder services" in this chart. **Drugs and biologicals that you can't give yourself**, see "Medicare Part B prescription drugs" in this chart.

Cost	2024 (this year)	2025 (next year)
Outpatient mental health care	**In-Network:** You pay $25 for each individual or group therapy visit for Medicare-covered outpatient mental health services. **Out-of-Network:** You pay 40% coinsurance for each individual or group therapy visit for Medicare-covered outpatient mental health services.	**In-Network:** You pay $25 for each individual or group therapy visit for Medicare-covered outpatient mental health services. **Out-of-Network:** You pay 45% coinsurance for each individual or group therapy visit for Medicare-covered outpatient mental health services. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Outpatient rehabilitation services	**In-Network:** You pay $40 for each Medicare-covered physical therapy, occupational therapy, or speech/language therapy visit. You pay $0 for a post-outpatient surgical procedure physical therapy or occupational therapy consultation prior to discharge. **Out-of-Network:** You pay 40% coinsurance for each Medicare-covered physical therapy visit, occupational therapy or speech/ language therapy visit.	**In-Network:** You pay $30 for each Medicare-covered physical therapy, occupational therapy, or speech/language therapy visit. You pay $0 for a post-outpatient surgical procedure physical therapy or occupational therapy consultation prior to discharge. **Out-of-Network:** You pay 45% coinsurance for each Medicare-covered physical therapy visit, occupational therapy or speech/ language therapy visit. Except in an emergency, prior authorization may be required before you receive this service in-network. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Outpatient substance use disorder services	**In-Network:** You pay $25 for each individual or group therapy visit for Medicare-covered outpatient substance use disorder services. **Out-of-Network:** You pay 40% coinsurance for each individual or group therapy visit for Medicare-covered outpatient substance use disorder services.	**In-Network:** You pay $25 for each individual or group therapy visit for Medicare-covered outpatient substance use disorder services. **Out-of-Network:** You pay 45% coinsurance for each individual or group therapy visit for Medicare-covered outpatient substance use disorder services. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	**In-Network:** You pay $0 for Medicare-covered colonoscopies. You pay $290 per day for other outpatient procedures and services, including, but not limited to, diagnostic and therapeutic endoscopy, and outpatient surgery performed in an ambulatory surgical center. You pay $390 per day for other outpatient procedures and services, including, but not limited to, diagnostic and therapeutic endoscopy, and outpatient surgery performed in an outpatient hospital.	**In-Network:** You pay $0 for Medicare-covered colonoscopies. You pay $290 per day for other outpatient procedures and services, including, but not limited to, diagnostic and therapeutic endoscopy, and outpatient surgery performed in an ambulatory surgical center. You pay $390 per day for other outpatient procedures and services, including, but not limited to, diagnostic and therapeutic endoscopy, and outpatient surgery performed in an outpatient hospital.

Cost	2024 (this year)	2025 (next year)
	Out-of-Network: You pay 40% coinsurance for outpatient procedures and services, including, but not limited to, diagnostic and therapeutic endoscopy, and outpatient surgery performed at hospital outpatient facilities and ambulatory surgical centers. Except in an emergency, prior authorization may be required before you receive this service in-network.	**Out-of-Network:** You pay 45% coinsurance for outpatient procedures and services, including, but not limited to, diagnostic and therapeutic endoscopy, and outpatient surgery performed at hospital outpatient facilities and ambulatory surgical centers. Except in an emergency, prior authorization may be required before you receive this service in-network. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Over-the-Counter (OTC) for Medicare Items	You receive $60 credit per calendar quarter to use toward Medicare-approved Over-the-Counter (OTC) items. You are responsible for purchases of Medicare-approved OTC items that exceed this quarterly benefit limit. Any unused balance at the end of a calendar quarter will not roll over into the following calendar quarter.	You receive $130 credit per calendar quarter to use toward Medicare-approved Over-the-Counter (OTC) items. You are responsible for purchases of Medicare-approved OTC items that exceed this quarterly benefit limit. Any unused balance at the end of a calendar quarter will not roll over into the following calendar quarter. Do not throw out your current Visa Flex Advantage spending card. You will continue to use your current card to access your dental and OTC benefits in 2025. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Partial hospitalization services and intensive outpatient services	**In-Network:** You pay $0 for partial hospitalization services and intensive outpatient services if a network provider certifies that inpatient treatment would be necessary without it. **Out-of-Network:** You pay 40% coinsurance for partial hospitalization services and intensive outpatient services if a provider certifies that inpatient treatment would be necessary without it.	**In-Network:** You pay $0 for partial hospitalization services and intensive outpatient services if a network provider certifies that inpatient treatment would be necessary without it. **Out-of-Network:** You pay 45% coinsurance for partial hospitalization services and intensive outpatient services if a provider certifies that inpatient treatment would be necessary without it. Please refer to your *Evidence of Coverage* for more information.
Podiatry services	**In-Network and Out-of-Network:** You pay $45 per visit for Medicare-covered services.	**In-Network and Out-of-Network:** You pay $40 per visit for Medicare-covered services. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Prostate cancer screening exams	**In-Network:** There is no coinsurance, copayment, or deductible for each Medicare-covered digital rectal exam or for an annual Prostate Specific Antigen (PSA) test. **Out-of-Network:** You pay 40% coinsurance for each Medicare-covered digital rectal exam or for an annual Prostate Specific Antigen (PSA) test.	**In-Network and Out-of-Network:** There is no coinsurance, copayment, or deductible for each Medicare-covered digital rectal exam or for an annual Prostate Specific Antigen (PSA) test. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Pulmonary rehabilitation services	**In-Network:** You pay $15 per visit for Medicare-covered services. **Out-of-Network:** You pay 40% coinsurance for Medicare-covered services.	**In-Network:** You pay $15 per visit for Medicare-covered services. **Out-of-Network:** You pay 45% coinsurance for Medicare-covered services. Except in an emergency, prior authorization may be required before you receive this service in-network. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Screening and counseling to reduce alcohol misuse	**In-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit. **Out-of-Network:** You pay 40% coinsurance for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.	**In-Network and Out-of-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Screening for lung cancer with low dose computed tomography (LDCT)	**In-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT. **Out-of-Network:** You pay 40% coinsurance for the Medicare-covered counseling and shared decision-making visit or for the LDCT.	**In-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT. **Out-of-Network:** You pay 45% coinsurance for the Medicare-covered counseling and shared decision-making visit or for the LDCT. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs	**In-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit. **Out-of-Network:** You pay 40% coinsurance for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.	**In-Network and Out-of-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit. Please refer to your *Evidence of Coverage* for more information.
Services to treat kidney disease - dialysis	**In-Network:** You pay 20% coinsurance for Medicare-covered dialysis services. **Out-of-Network:** You pay 40% coinsurance for Medicare-covered dialysis services.	**In-Network:** You pay 20% coinsurance for Medicare-covered dialysis services. **Out-of-Network:** You pay 45% coinsurance for Medicare-covered dialysis services. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Services to treat kidney disease - education	**In-Network:** You pay $0 for kidney disease education services. **Out-of-Network:** You pay 40% coinsurance for kidney disease education services.	**In-Network:** You pay $0 for kidney disease education services. **Out-of-Network:** You pay 45% coinsurance for kidney disease education services. Please refer to your *Evidence of Coverage* for more information.
Skilled nursing facility (SNF) care	**In-Network:** For each admission you pay $0 for days 1-20 of a benefit period, $190 per day for days 21-44, and $0 for days 45-100 of a benefit period. **Out-of-Network:** You pay 40% coinsurance for each admission, up to 100 days. Except in an emergency, prior authorization may be required before you receive this service in-network.	**In-Network:** For each admission you pay $0 for days 1-20 of a benefit period, $190 per day for days 21-44, and $0 for days 45-100 of a benefit period. **Out-of-Network:** You pay 45% coinsurance for each admission, up to 100 days. Except in an emergency, prior authorization may be required before you receive this service in-network. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)	**In-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits. **Out-of-Network:** You pay 40% coinsurance for the Medicare-covered smoking and tobacco use cessation preventive benefits.	**In-Network and Out-of-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Supervised Exercise Therapy (SET) for Peripheral Artery Disease (PAD)	**In-Network:** You pay $25 per visit for Medicare-covered services. **Out-of-Network:** You pay 40% coinsurance for Medicare-covered services.	**In-Network:** You pay $25 per visit for Medicare-covered services. **Out-of-Network:** You pay 45% coinsurance for Medicare-covered services. Except in an emergency, prior authorization may be required before you receive this service in-network. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Telehealth - Remote Patient Monitoring (RPM)	**In-Network:** You pay $0 for remote patient monitoring services rendered by your PCP or Specialist. **Out-of-Network:** Remote patient monitoring is not covered.	**In-Network:** You pay $0 for remote patient monitoring services rendered by your PCP or Specialist. **Out-of-Network:** Remote patient monitoring is not covered. Except in an emergency, prior authorization may be required before you receive this service in-network. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Urgently needed care	**In-Network and Out-of-Network:** You pay $45 per visit for each Medicare-covered urgent care visit. This copayment is not waived if you are admitted as an inpatient to the hospital within 24 hours for the same condition.	**In-Network and Out-of-Network:** You pay $45 per visit for each Medicare-covered urgent care visit. This copayment is not waived if you are admitted as an inpatient to the hospital within one day for the same condition. Please refer to your *Evidence of Coverage* for more information.
Vision - Diabetic retinopathy	**In-Network** and **Out-of-Network:** You pay $0 for an annual diabetic retinopathy screening by an optometrist and $45 when the screening is performed by a specialist.	**In-Network:** You pay $0 or $40 for an annual diabetic retinopathy screening by an optometrist or a specialist, depending on the type of vision service you receive. **Out-of-Network:** You pay $40 for an annual diabetic retinopathy screening. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Vision - Diagnostic eye exam	**In-Network and Out-of-Network:** You pay $45 for each Medicare-covered outpatient visit to diagnose and/or treat a disease or condition of the eye.	**In-Network and Out-of-Network:** You pay $40 for each Medicare-covered outpatient visit to diagnose and/or treat a disease or condition of the eye. Please refer to your *Evidence of Coverage* for more information.
Vision - Eyewear benefit	You receive an allowance of $150 per calendar year toward purchase of standard eyeglasses (prescription lenses, frames, or a combination of lenses and frames) and/or contact lenses.	You receive an allowance of $250 per calendar year toward purchase of standard eyeglasses (prescription lenses, frames, or a combination of lenses and frames) and/or contact lenses, including upgrades. The annual allowance may be used to purchase upgrades for Medicare-covered and/or therapeutic eyewear as well as routine/corrective eyewear. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Vision - Glaucoma screening	**In-Network:** You pay $0 for an annual glaucoma screening by a provider in the EyeMed Vision Care network if you are at high risk. If you receive this service as part of an office visit that addresses a medical condition, you pay a $45 specialist office visit copayment. **Out-of-Network:** You pay $45 per visit for an annual glaucoma screening if you are at high risk.	**In-Network:** You pay $0 for an annual glaucoma screening by a provider in the EyeMed Vision Care network if you are at high risk. If you receive this service as part of an office visit that addresses a medical condition, you pay a $40 specialist office visit copayment. **Out-of-Network:** You pay $40 per visit for an annual glaucoma screening if you are at high risk. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Vision - Routine eye exam	**In-Network:** You pay $0 for one annual routine eye exam when rendered by a provider in the EyeMed Vision Care network. If you receive services that address a medical condition during the same office visit, you pay a $45 specialist office visit copayment. **Out-of-Network:** You pay $45 for one annual routine eye exam when rendered by a U.S. provider who is not part of the EyeMed Vision Care network.	**In-Network:** You pay $0 for one annual routine eye exam when rendered by a provider in the EyeMed Vision Care network. If you receive services that address a medical condition during the same office visit, you pay a $40 specialist office visit copayment. **Out-of-Network:** You pay $40 for one annual routine eye exam when rendered by a U.S. provider who is not part of the EyeMed Vision Care network. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Vision - Therapeutic eyewear (Medicare covered & Supplemental coverage)	**In-Network:** You pay $0 for one pair of standard eyeglasses with standard frames or contact lenses for Keratoconus, Anisometropia, High Myopia, Aphakia, Congenital Aphakia, or Pseudoaphakia when obtained from a provider in the EyeMed Vision Care network. You will pay any cost over the allowed charge.	**In-Network:** You pay $0 for one pair of standard eyeglasses with standard frames or contact lenses for Keratoconus, Anisometropia, High Myopia, Aphakia, Congenital Aphakia, or Pseudoaphakia when obtained from a provider in the EyeMed Vision Care network. You may use your eyewear allowance through EyeMed to purchase upgrades (i.e., non-standard frames and/or lenses) for your therapeutic eyewear. Once your eyewear allowance is exhausted, however, you will be responsible for any remaining balance.
	You pay $0 for one pair of Medicare-covered standard eyeglasses with standard frames or contact lenses after cataract surgery when obtained from a provider in the EyeMed Vision Care network. You will pay any cost over the Medicare-allowed charge if you	You pay $0 for one pair of Medicare-covered standard eyeglasses with standard frames or contact lenses after cataract surgery when obtained from a provider in the EyeMed Vision Care network. You may use your eyewear allowance through EyeMed to purchase

Cost	2024 (this year)	2025 (next year)
	purchase upgraded frames. **<u>Out-of-Network:</u>** You pay $45 for one pair of standard eyeglasses with standard frames or contact lenses for Keratoconus, Anisometropia, High Myopia, Aphakia, Congenital Aphakia, or Pseudoaphakia when obtained from a U.S. provider who is not part of the EyeMed Vision Care network. You will pay any cost over the allowed charge.	upgrades (i.e., non-standard frames and/or lenses) for your Medicare-covered eyewear. Once your eyewear allowance is exhausted, however, you will be responsible for any remaining balance. **<u>Out-of-Network:</u>** You pay $40 for one pair of standard eyeglasses with standard frames or contact lenses for Keratoconus, Anisometropia, High Myopia, Aphakia, Congenital Aphakia, or Pseudoaphakia when obtained from a U.S. provider who is not part of the EyeMed Vision Care network. You may use your eyewear allowance through EyeMed to purchase upgrades (i.e., non-standard frames and/or lenses) for your therapeutic eyewear. Once your eyewear allowance is exhausted, however, you will be responsible for any remaining balance.

Cost	2024 (this year)	2025 (next year)
	You pay $45 for one pair of Medicare-covered standard eyeglasses with standard frames or contact lenses after cataract surgery when obtained from a U.S. provider who is not part of the EyeMed Vision Care network. You will pay any cost over the Medicare-allowed charge if you purchase upgraded frames.	You pay $40 for one pair of Medicare-covered standard eyeglasses with standard frames or contact lenses after cataract surgery when obtained from a U.S. provider who is not part of the EyeMed Vision Care network. You may use your eyewear allowance through EyeMed to purchase upgrades (i.e., non-standard frames and/or lenses) for your Medicare-covered eyewear. Once your eyewear allowance is exhausted, however, you will be responsible for any remaining balance. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Welcome to Medicare preventive visit	**In-Network:** There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit. You pay $30 per day for a one-time Medicare-covered EKG screening ordered as a result of your "Welcome to Medicare" preventive visit. **Out-of-Network:** You pay 40% coinsurance for the "Welcome to Medicare" preventive visit. You pay 40% coinsurance for a one-time Medicare-covered EKG screening ordered as a result of your "Welcome to Medicare" preventive visit.	**In-Network:** There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit. You pay $30 per day for a one-time Medicare-covered EKG screening ordered as a result of your "Welcome to Medicare" preventive visit. **Out-of-Network:** You pay $0 for the "Welcome to Medicare" preventive visit. You pay 45% coinsurance for a one-time Medicare-covered EKG screening ordered as a result of your "Welcome to Medicare" preventive visit. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Wellness Allowance	The plan reimburses you up to $350 per calendar year towards certain health and wellness education programs. Please refer to your *Evidence of Coverage* for details of covered items, activities, and programs.	The plan reimburses you up to $185 per calendar year towards certain health and wellness education programs. The following additional items, activities, and programs will be covered: • Certain home fitness equipment • Alternative therapies • Fitness tracking devices and heart rate monitors • Massage therapy • Additional types of fitness clubs and classes Please refer to your *Evidence of Coverage* for more information.

Section 1.5 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or Drug List. A copy of our Drug List is provided electronically.

We made changes to our Drug List, which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs or moving them to a different cost-sharing tier. **Review the Drug List to make sure your drugs will be covered next year and**

to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.

In 2025, certain Medicare-excluded drugs are covered under our enhanced drug coverage. Covered drugs include select erectile dysfunction (ED) drugs, vitamins and minerals, and cough/cold products. Tier 1 or Tier 2 copays apply depending on the drug.

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you are taking, we will send you a notice about the change.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your *Evidence of Coverage* and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Member Services for more information.

Changes to Prescription Drug Benefits and Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We have included a separate insert, called the *Evidence of Coverage Rider for People Who Get "Extra Help" Paying for Prescription Drugs* (also called the *Low Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug costs. If you receive "Extra Help" and didn't receive this insert with this packet, please call Member Services and ask for the *LIS Rider*.

Beginning in 2025, there are three **drug payment stages:** the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program will no longer exist in the Part D benefit.

The Coverage Gap Discount Program will also be replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

Changes to the Deductible Stage

Stage	2024 (this year)	2025 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

For drugs on Tier 3 and Tier 4, your cost sharing in the Initial Coverage Stage is changing from a copayment to coinsurance. Please see the following chart for the changes from 2024 to 2025.

Stage	2024 (this year)	2025 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** For 2024, you paid a $47 copayment for drugs on Tier 3. For 2025, you will pay 23% coinsurance for drugs on this tier. For 2024, you paid a $100 copayment for drugs on Tier 4. For 2025, you will pay 50% coinsurance for drugs on this tier. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List. Most adult Part D vaccines are covered at no cost to you. Tier 1 and Tier 2 drugs include enhanced coverage of certain drugs such as select erectile dysfunction (ED) drugs, vitamins and minerals, and cough/cold products.	Your cost for a one-month supply is: **Tier 1:** *Preferred cost-sharing:* You pay $0 per prescription. *Standard cost-sharing:* You pay $14 per prescription. Your cost for a one-month mail-order prescription is $0. **Tier 2:** *Preferred cost-sharing:* You pay $4 per prescription. *Standard cost-sharing:* You pay $19 per prescription. Your cost for a one-month mail-order prescription is $4.	Your cost for a one-month supply is: **Tier 1:** *Preferred cost-sharing:* You pay $0 per prescription. *Standard cost-sharing:* You pay $14 per prescription. Your cost for a one-month mail-order prescription is $0. **Tier 2:** *Preferred cost-sharing:* You pay $8 per prescription. *Standard cost-sharing:* You pay $20 per prescription. Your cost for a one-month mail-order prescription is $8.

Stage	2024 (this year)	2025 (next year)
	Tier 3: *Preferred cost-sharing:* You pay $47 per prescription. You pay $35 per month supply of each covered insulin product on this tier. *Standard cost-sharing:* You pay $47 per prescription. You pay $35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is $47. You pay $35 per month supply of each covered insulin product on this tier.	**Tier 3:** *Preferred cost-sharing:* You pay 23% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. *Standard cost-sharing:* You pay 23% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is 23% coinsurance. You pay $35 per month supply of each covered insulin product on this tier.

Stage	2024 (this year)	2025 (next year)
	Tier 4: *Preferred cost-sharing:* You pay $100 per prescription. You pay $35 per month supply of each covered insulin product on this tier. *Standard cost-sharing:* You pay $100 per prescription. You pay $35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is $100. You pay $35 per month supply of each covered insulin product on this tier. **Tier 5:** *Preferred cost-sharing:* You pay 33% of the total cost. *Standard cost-sharing:* You pay 33% of the total cost. Your cost for a one-month mail-order prescription is 33% coinsurance.	**Tier 4:** *Preferred cost-sharing:* You pay 50% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. *Standard cost-sharing:* You pay 50% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is 50% coinsurance. You pay $35 per month supply of each covered insulin product on this tier. **Tier 5:** *Preferred cost-sharing:* You pay 33% of the total cost. *Standard cost-sharing:* You pay 33% of the total cost. Your cost for a one-month mail-order prescription is 33% coinsurance.

Stage	2024 (this year)	2025 (next year)
	Tier 6: *Preferred cost-sharing:* You pay $0 for all Tier 6 vaccines. *Standard cost-sharing:* You pay $0 for all Tier 6 vaccines. Mail-order is not available for drugs in Tier 6.	**Tier 6:** *Preferred cost-sharing:* You pay $0 for all Tier 6 vaccines. *Standard cost-sharing:* You pay $0 for all Tier 6 vaccines. Mail-order is not available for drugs in Tier 6.
	Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage).	Once you have paid $2,000 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

Changes to the Catastrophic Coverage Stage

The Catastrophic Coverage Stage is the third and final stage. Beginning in 2025, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

If you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.

For specific information about your costs in Catastrophic Coverage Stage, look at Chapter 6, Section 6 in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

Description	2024 (this year)	2025 (next year)
Medicare Prescription Payment Plan	Not applicable	The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). To learn more about this payment option, please contact us at 1-866-623-0172 or visit Medicare.gov.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Tufts Medicare Preferred Access

To stay in our plan, you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our Tufts Medicare Preferred Access plan.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year, but if you want to change plans for 2025 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,

- – *OR* – You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2025* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

As a reminder, Tufts Associated Health Maintenance Organization (Tufts Health Plan) offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and costsharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Tufts Medicare Preferred Access.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Tufts Medicare Preferred Access.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Member Services if you need more information on how to do so.
    - – *OR* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2025.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. Examples include people with Medicaid, those who get “Extra Help” paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

If you enrolled in a Medicare Advantage Plan for January 1, 2025, and don’t like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2025.

If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage)

or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

SECTION 5 Programs That Offer Free Counseling About Medicare

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

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. SHINE counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call SHINE at 1-800-243-4636 (TTY: 1-800-439-2370). You can learn more about SHINE by visiting their website (www.mass.gov/health-insurance-counseling).

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, yearly deductibles, and coinsurance. Additionally, those who qualify will not have a late enrollment penalty. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
    - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday, for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
    - Your State Medicaid Office.
- **Help from your state's pharmaceutical assistance program.** Massachusetts has a program called Prescription Advantage that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program.

- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Massachusetts HIV Drug Assistance Program (HDAP) at 1-617-502-1700. For information on eligibility criteria, covered drugs, how to enroll in the program or if you are currently enrolled how to continue receiving assistance, call the Massachusetts HDAP at 1-617-502-1700. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.

- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a new payment option to help you manage your out-of-pocket drug costs, starting in 2025. This new payment option works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

  "Extra Help" from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in this payment option, regardless of income level, and all Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. To learn more about this payment option, please contact us at 1-866-623-0172 or visit Medicare.gov.

SECTION 7 Questions?

Section 7.1 – Getting Help from Tufts Medicare Preferred Access

Questions? We're here to help. Please call Member Services at 1-866-623-0172. (TTY only, call 711). We are available for phone calls from 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31 and Monday - Friday from April 1 to September 30. Calls to these numbers are free.

Read your 2025 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2025. For details, look in the 2025 *Evidence of Coverage* for Tufts Medicare Preferred Access. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at www.thpmp.org. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.thpmp.org. As a reminder, our website has the most up-to-date information about our provider network (*Provider and Pharmacy Directory*) and our *List of Covered Drugs (Formulary/Drug List)*.

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

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

Visit the Medicare Website

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2025*

Read the *Medicare & You 2025* handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or 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.

TUFTS Health Plan

a Point32Health company

Form Approved
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.

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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