TUFTS Health Plan

2027 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 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, 2027–December 31, 2027

H2256_2027_1093_M

Summary of Benefits

January 1, 2027–December 31, 2027

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 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 select erectile dysfunction (ED) drugs. In addition, all plans cover Part B drugs such as chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, **www.thpmp.org**.

How will I determine my drug costs for Tufts Medicare Preferred HMO Smart 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 reach your deductible (if applicable): Initial Coverage and Catastrophic Coverage.

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

Monthly Plan Premium	Tufts Medicare Preferred **HMO Smart Saver Rx**	Tufts Medicare Preferred **HMO Basic No Rx**	Tufts Medicare Preferred **HMO Basic Rx**	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**
Middlesex, Norfolk, Plymouth, Barnstable, Bristol	$0 per month	Not offered	$82 per month	$133 per month	$185 per month	$163 per month	$214 per month	$252 per month
Essex, Suffolk	$0 per month	$58 per month	$88 per month	$153 per month	$207 per month	$186 per month	$244 per month	$280 per month
Hampden, Hampshire	$0 per month	Not offered	$65 per month	Not offered	$108 per month	Not offered	$138 per month	$158 per month
Worcester	$0 per month	$50 per month	$85 per month	$142 per month	$190 per month	$182 per month	$224 per month	Not offered
What you should know	In addition, you must keep paying your Medicare Part B premium.							
Deductible (for Part D prescription drugs)	$700 per year for your Tier 3, Tier 4 and Tier 5 drugs.	This plan does not cover prescription drugs.	$200 per year for your Tier 3, Tier 4 and Tier 5 drugs.	This plan does not cover prescription drugs.	$200 per year for your Tier 3, Tier 4 and Tier 5 drugs.	This plan does not cover prescription drugs.	This plan does not have a deductible.	This plan does not have a deductible.

A note about this chart: HMO Smart Saver Rx has different copays depending on the county you live in. Please refer to this legend for your region:

Region A
Hampden, Hampshire, Middlesex and Worcester Counties

Region B
Bristol, Essex, Norfolk, Plymouth and Suffolk Counties

Region C
Barnstable County

Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	Tufts Medicare Preferred **HMO Smart Saver Rx**	Tufts Medicare Preferred **HMO Basic No Rx**	Tufts Medicare Preferred **HMO Basic Rx**	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**
	Region A $7,150 Region B $7,150 Region C $9,850	$4,500	$4,500	$4,200	$4,200	$3,850	$3,850	$3,850
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 Basic No Rx**	Tufts Medicare Preferred **HMO Basic Rx**	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								
Inpatient hospital care	Region A $459 copay per day for days 1 through 6; You pay nothing after day 6 Region B $550 copay per day for days 1 through 5; You pay nothing after day 5 Region C $490 copay per day for days 1 through 5; You pay nothing after day 5	$350 copay per day for days 1 through 5; You pay nothing after day 5	$350 copay per day for days 1 through 5; You pay nothing after day 5	$300 copay per day for days 1 through 5; You pay nothing after day 5	$300 copay per day for days 1 through 5; You pay nothing after day 5	$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.
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	Region A $370 copay per day Region B $450 copay per day Region C $450 copay per day	$300 copay per day	$300 copay per day	$250 copay per day	$250 copay per day	$200 copay per day	$200 copay per day	$175 copay per day
Outpatient surgery (services provided at hospital outpatient facilities)	Colonoscopies: $0 copay; Other services: Region A $370 copay per day Region B $450 copay per day Region C $450 copay per day	Colonoscopies: $0 copay; Other services: $300 copay per day	Colonoscopies: $0 copay; Other services: $300 copay per day	Colonoscopies: $0 copay; Other services: $250 copay per day	Colonoscopies: $0 copay; Other services: $250 copay per day	Colonoscopies: $0 copay; Other services: $200 copay per day	Colonoscopies: $0 copay; Other services: $200 copay per day	Colonoscopies: $0 copay; Other services: $175 copay per day
Ambulatory surgical center (ASC) services	Colonoscopies: $0 copay; Other services: Region A $270 copay per day Region B $350 copay per day Region C $350 copay per day	Colonoscopies: $0 copay; Other services: $170 copay per day	Colonoscopies: $0 copay; Other services: $170 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
What you should know	A referral may be required from your PCP before you receive these services. Your PCP will provide this referral if needed.							

Inpatient and Outpatient Care and Services	Tufts Medicare Preferred **HMO Smart 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
Specialist	Region A: $60 copay per visit; Region B: $70 copay per visit; Region C: $60 copay per visit	$45 copay per visit	$45 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. A referral may be required from your PCP before you receive services from a specialist. Your PCP will provide this referral if needed.		
Preventive Care (Medicare preventive services)	$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	Region A: $130 copay per visit; Region B: $130 copay per visit; Region C: $115 copay per visit	$130 copay per visit	$130 copay per visit
What you should know	If you are held for observation or admitted to the hospital within one day for the same condition, the emergency care copay or the applicable observation/inpatient cost share will apply, whichever is higher. Your plan includes worldwide coverage for emergency care.		
Urgently needed services	Region A: $50 copay per visit; Region B: $50 copay per visit; Region C: $40 copay per visit	$45 copay per visit	$45 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 one day. Your plan includes worldwide coverage for urgently needed care.		
Diagnostic Services/Labs/Imaging			
Diagnostic radiology services (such as MRIs, CT scans)	Region A: $295 copay per day for ultrasound; $350 copay per day for all other services; Region B: $195 copay per day for ultrasound; $350 copay per day for all other services; Region C: $145 copay per day for ultrasound; $350 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; $350 copay per day for all other services
Diagnostic tests and procedures	$20 copay per day	$20 copay per day	$20 copay per day
Lab services	$0 copay	$0 copay	$0 copay
Outpatient X-rays	$20 per day	$20 per day	$20 per day
What you should know	There is no copay for diagnostic tests and procedures, lab services and outpatient X-rays performed and billed as part of an office or urgent care visit. Prior authorization may be required.		
Hearing Services			
Exam to diagnose and treat hearing and balance issues	$40 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
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 TruHearing, Inc. to receive the Hearing Aid benefit. Up to 2 hearing aids per year, 1 hearing aid per ear. Hearing aid fitting is provided by TruHearing, Inc. at no cost.		
Dental			
Limited Medicare-covered dental services	$40 copay per visit	$40 copay per visit	$40 copay per visit
What you should know	Prior authorization may be required. Limited Medicare-covered dental services do not include preventive dental services such as cleanings, routine dental exams and dental X-rays. A referral may be required from your PCP before you receive these services. Your PCP will provide this referral if needed.		

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
$35 copay per visit	$35 copay per visit	$20 copay per visit	$30 copay per visit	$30 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. A referral may be required from your PCP before you receive services from a specialist. Your PCP will provide this referral if needed.				
$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Any additional preventive services approved by Medicare during the contract year will be covered.				
$130 copay per visit	$130 copay per visit	$130 copay per visit	$130 copay per visit	$130 copay per visit
If you are held for observation or admitted to the hospital within one day for the same condition, the emergency care copay or the applicable observation/inpatient cost share will apply, whichever is higher. 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 one day. 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
There is no copay for diagnostic tests and procedures, lab services and outpatient X-rays performed and billed as part of an office or urgent care visit. 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 TruHearing, Inc. to receive the Hearing Aid benefit. Up to 2 hearing aids per year, 1 hearing aid per ear. Hearing aid fitting is provided by TruHearing, Inc. at no cost.				
Dental				
$25 copay per visit	$25 copay per visit	$15 copay per visit	$15 copay per visit	$15 copay per visit
Prior authorization may be required. Limited Medicare-covered dental services do not include preventive dental services such as cleanings, routine dental exams and dental X-rays. A referral may be required from your PCP before you receive these services. Your PCP will provide this referral if needed.				

Inpatient and Outpatient Care and Services	Tufts Medicare Preferred **HMO Smart Saver Rx**			Tufts Medicare Preferred **HMO Basic No Rx**	Tufts Medicare Preferred **HMO Basic Rx**	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**
Embedded supplemental dental benefit	Region A $1,000 calendar year maximum	Region B $750 calendar year maximum	Region C $500 calendar year maximum • $0 copay for preventive services such as routine cleanings, oral exams and bitewing X-rays; 50% 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 cleanings and oral exams, and 50% coinsurance for basic services such as fillings and simple extractions. • $0 deductible. • No waiting period.	• $1,000 calendar year maximum. • $0 copay for preventive services such as cleanings and oral exams, and 50% coinsurance for basic services such as fillings and simple extractions. • $0 deductible. • No waiting period.	• $1,000 calendar year maximum. • $0 copay for preventive services such as cleanings and oral exams, and 50% coinsurance for basic services such as fillings and simple extractions. • $0 deductible. • No waiting period.	• $1,000 calendar year maximum. • $0 copay for preventive services such as cleanings and oral exams, and 50% coinsurance for basic services such as fillings and simple extractions. • $0 deductible. • No waiting period.	Not covered	Not covered	Not covered
What you should know	Coverage is limited to providers within the Dominion PPO network. Other benefit limits apply.					Coverage is limited to providers within the Dominion PPO network. Other benefit limits apply.		N/A	N/A	N/A
Tufts Medicare Preferred Dental Option	N/A			Covered with additional premium. See the Optional Benefits section for more information.		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	$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	$15 copay per visit ($0 for diabetic retinopathy)			$15 copay per visit ($0 for diabetic retinopathy)	$15 copay per visit ($0 for diabetic retinopathy)	$15 copay per visit ($0 for diabetic retinopathy)	$15 copay per visit ($0 for diabetic retinopathy)	$15 copay per visit ($0 for diabetic retinopathy)	$15 copay per visit ($0 for diabetic retinopathy)	$15 copay per visit ($0 for diabetic retinopathy)
Annual glaucoma screening	$0 copay per visit			$0 copay per visit	$0 copay per visit	$0 copay per visit	$0 copay per visit	$0 copay per visit	$0 copay per visit	$0 copay per visit
Annual eyewear benefit	Region A Up to $150 allowance per calendar year	Region B Up to $150 allowance per calendar year	Region C Not covered	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	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. The eyewear allowance may be applied toward the purchase of glasses, frames, prescription lenses and/or contact lenses. Only one purchase is allowed per calendar year up to the benefit amount; any unused amount after the single purchase will expire and cannot be applied toward another purchase during the calendar year. A referral may be required from your PCP before you receive a diagnostic eye exam. Your PCP will provide this referral if needed.					You must use a participating vision care provider (EyeMed Vision Care) to receive the covered Routine Eye Exam benefit. The eyewear allowance may be applied toward the purchase of glasses, frames, prescription lenses and/or contact lenses. Only one purchase is allowed per calendar year up to the benefit amount; any unused amount after the single purchase will expire and cannot be applied toward another purchase during the calendar year. A referral may be required from your PCP before you receive a diagnostic eye exam. Your PCP will provide this referral if needed.				
Mental Health Services										
Inpatient care visit	Region A $450 copay per day for days 1 through 5; $0 copay for day 6 and beyond	Region B $550 copay per day for days 1 through 4; $0 copay for day 5 and beyond	Region C $490 copay per day for days 1 through 4; $0 copay for day 5 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.	$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.
Outpatient group or individual therapy visit	$30 copay per visit			$25 copay per visit	$25 copay per visit	$20 copay per visit	$20 copay per visit	$10 copay per visit	$10 copay per visit	$10 copay per visit
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.					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.				
Skilled Nursing Facility (SNF)										
Skilled nursing facility (SNF)	$0 copay per day for days 1 through 20; $221 copay per day for days 21 through 100			$0 copay per day for days 1 through 20; $170 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; $170 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; $150 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; $150 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; $110 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; $110 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; $80 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 an SNF per benefit period. No prior hospital stay is required. Prior authorization may be required.					Our plans cover up to 100 days in an SNF per benefit period. No prior hospital stay is required. Prior authorization may be required.				

Inpatient and Outpatient Care and Services	Tufts Medicare Preferred **HMO Smart Saver Rx**	Tufts Medicare Preferred **HMO Basic No Rx**	Tufts Medicare Preferred **HMO Basic Rx**
Physical Therapy			
Occupational therapy	$30 copay per visit	$30 copay per visit	$30 copay per visit
Physical therapy, and speech and language therapy	$30 copay per visit	$30 copay per visit	$30 copay per visit
What you should know	Prior authorization may be required. A referral may be required from your PCP before you receive these services. Your PCP will provide this referral if needed.		
Ambulance			
Ambulance	$375 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	Not covered	$0 copay per ride	$0 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 home or 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 may 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**
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
Prior authorization may be required. A referral may be required from your PCP before you receive these services. Your PCP will provide this referral if needed.				
Ambulance				
$225 copay per one-way trip	$225 copay per one-way trip	$175 copay per one-way trip	$175 copay per one-way trip	$150 copay per one-way trip
Prior authorization may be required for non-emergency transportation.				
Transportation				
$0 copay per ride	$0 copay per ride	$0 copay per ride	$0 copay per ride	$0 copay per ride
Non-ambulance transportation (e.g., by chair car/wheelchair van or sedan) through the plan-approved vendor from a hospital to home or 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.	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.	For Part B chemotherapy drugs: $0 copay; Insulin: $0 copay per 30-day supply; Other Part B drugs: $0 copay.	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.	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.
For Value Rx, Prime Rx, and Prime Rx Plus ONLY: Your actual coinsurance rate for non-insulin Medicare Part B drugs each quarter may 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.				

Prescription Drug Benefits: Deductible (for Part D prescription drugs)	Tufts Medicare Preferred **HMO Smart Saver Rx**	Tufts Medicare Preferred **HMO Basic No Rx**	Tufts Medicare Preferred **HMO Basic Rx**
Deductible	$700 per year for your Tier 3, Tier 4 and Tier 5 drugs.	This plan does not cover Part D prescription drugs.	$200 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 Basic No Rx**	Tufts Medicare Preferred **HMO Basic Rx**
Note: Tier 1 and Tier 2 drugs include enhanced coverage of select erectile dysfunction (ED) drugs.	After you pay your yearly deductible of $700 for Tier 3, Tier 4 and Tier 5 drugs, you pay the Tier 3, Tier 4 or Tier 5 copays listed on page 12 until your total yearly drug costs reach $2,400. 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 $200 for Tier 3, Tier 4 and Tier 5 drugs, you pay the Tier 3, Tier 4 or Tier 5 copays listed on page 12 until your total yearly drug costs reach $2,400. 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 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.	$200 per year for your Tier 3, Tier 4 and Tier 5 drugs.	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.	After you pay your yearly deductible of $200 for Tier 3, Tier 4 and Tier 5 drugs, you pay the Tier 3, Tier 4 or Tier 5 copays listed on page 13 until your total yearly drug costs reach $2,400. 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 the copays listed on page 13 until your total yearly drug costs reach $2,400. 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 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
Tier 1 (Preferred Generic)	$0	$0	$0 (100-day supply)	$0	$0	$0 (100-day supply)
Tier 2 (Generic)	$2	$4	$6	$4/$0*	$8/$0*	$12/$0*
Tier 3 (Preferred Brand)	20% of the cost (Insulin: $35)	20% of the cost (Insulin: $70)	20% of the cost (Insulin: $105)	20%/17%* of the cost (Insulin: $35)	20%/17%* of the cost (Insulin: $70)	20%/17%* of the cost (Insulin: $105)
Tier 4 (Non-Preferred Drug)	25% of the cost (Insulin: $35)	25% of the cost (Insulin: $70)	25% of the cost (Insulin: $105)	40% of the cost (Insulin: $35)	40% of the cost (Insulin: $70)	40% of the cost (Insulin: $105)
Tier 5 (Specialty Tier)	25% of the cost	N/A	N/A	30%/31%* of the cost	N/A	N/A
Tier 6 (Vaccines)	$0	N/A	N/A	$0	N/A	N/A
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
Tier 1 (Preferred Generic)	$5	$10	$15 (100-day supply)	$14/$6*	$28/$12*	$42/$18* (100-day supply)
Tier 2 (Generic)	$12	$24	$36	$19/$11*	$38/$22*	$57/$33*
Tier 3 (Preferred Brand)	20% of the cost (Insulin: $35)	20% of the cost (Insulin: $70)	20% of the cost (Insulin: $105)	20%/17%* of the cost (Insulin: $35)	20%/17%* of the cost (Insulin: $70)	20%/17%* of the cost (Insulin: $105)
Tier 4 (Non-Preferred Drug)	25% of the cost (Insulin: $35)	25% of the cost (Insulin: $70)	25% of the cost (Insulin: $105)	40% of the cost (Insulin: $35)	40% of the cost (Insulin: $70)	40% of the cost (Insulin: $105)
Tier 5 (Specialty Tier)	25% of the cost	N/A	N/A	30%/31%*of the cost	N/A	N/A
Tier 6 (Vaccines)	$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
Tier 1 (Preferred Generic)	$0	$0	$0 (100-day supply)	$0	$0	$0 (100-day supply)
Tier 2 (Generic)	$2	$4	$4	$4/$0*	$8/$0*	$8/$0*
Tier 3 (Preferred Brand)	20% of the cost (Insulin: $35)	20% of the cost (Insulin: $70)	20% of the cost (Insulin: $70)	20%/17%* of the cost (Insulin: $35)	20%/17%* of the cost (Insulin: $70)	20%/17%* of the cost (Insulin: $70)
Tier 4 (Non-Preferred Drug)	25% of the cost (Insulin: $35)	25% of the cost (Insulin: $70)	25% of the cost (Insulin: $70)	40% of the cost (Insulin: $35)	40% of the cost (Insulin: $70)	40% of the cost (Insulin: $70)
Tier 5 (Specialty Tier)	25% of the cost	N/A	N/A	30%/31%* of the cost	N/A	N/A
Tier 6 (Vaccines)	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 Tier 1, Tier 2 and Tier 6 drugs and you pay your share of the cost. After you have met your annual $700 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.			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 and Tier 6 drugs and you pay your share of the cost. After you have met your annual $200 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 — 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 (100-day supply)	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
20% of the cost (Insulin: $35)	20% of the cost (Insulin: $70)	20% of the cost (Insulin: $105)	N/A	N/A	N/A	N/A	N/A	N/A
40% of the cost (Insulin: $35)	40% of the cost (Insulin: $70)	40% of the cost (Insulin: $105)	N/A	N/A	N/A	N/A	N/A	N/A
27%/26%* 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
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 (100-day supply)	$4	$8	$12 (100-day supply)	$2	$4	$6 (100-day supply)
$19	$38	$57	$8	$16	$24	$4	$8	$12
20% of the cost (Insulin: $35)	20% of the cost (Insulin: $70)	20% of the cost (Insulin: $105)	20% of the cost (Insulin: $35)	20% of the cost (Insulin: $70)	20% of the cost (Insulin: $105)	20% of the cost (Insulin: $30)	20% of the cost (Insulin: $60)	20% of the cost (Insulin: $90)
40% of the cost (Insulin: $35)	40% of the cost (Insulin: $70)	40% of the cost (Insulin: $105)	40% of the cost (Insulin: $35)	40% of the cost (Insulin: $70)	40% of the cost (Insulin: $105)	40% of the cost (Insulin: $35)	40% of the cost (Insulin: $70)	40% of the cost (Insulin: $105)
27%/26%* of the cost	N/A	N/A	32%/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 (100-day supply)	$4	$8	$8 (100-day supply)	$2	$4	$4 (100-day supply)
$4	$8	$8	$8	$16	$16	$4	$8	$8
20% of the cost (Insulin: $35)	20% of the cost (Insulin: $70)	20% of the cost (Insulin: $70)	20% of the cost (Insulin: $35)	20% of the cost (Insulin: $70)	20% of the cost (Insulin: $70)	20% of the cost (Insulin: $30)	20% of the cost (Insulin: $60)	20% of the cost (Insulin: $60)
40% of the cost (Insulin: $35)	40% of the cost (Insulin: $70)	40% of the cost (Insulin: $70)	40% of the cost (Insulin: $35)	40% of the cost (Insulin: $70)	40% of the cost (Insulin: $70)	40% of the cost (Insulin: $35)	40% of the cost (Insulin: $70)	40% of the cost (Insulin: $70)
27%/26%* of the cost	N/A	N/A	32%/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 Tier 1, Tier 2 and Tier 6 drugs and you pay your share of the cost. After you have met your annual $200 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.			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: Catastrophic Coverage	Tufts Medicare Preferred **HMO Smart Saver Rx**	Tufts Medicare Preferred **HMO Basic Rx**	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 $2,400, you pay nothing for covered Part D drugs. During this payment stage, the plan pays the full cost for your covered Part D drugs. You can have cost sharing for excluded drugs that are covered under our enhanced benefit.		After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $2,400, you pay nothing for covered Part D drugs. During this payment stage, the plan pays the full cost for your covered Part D drugs. You can have cost sharing 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 Basic No Rx**	Tufts Medicare Preferred **HMO Basic Rx**	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								
Benefits include	N/A	• 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	• Preventive services • Basic and Major services	• Preventive services • Basic and Major services
Monthly premium	N/A	Additional $41.50 per month.	Additional $41.50 per month.	Additional $41.50 per month.	Additional $41.50 per month.	Additional $38.50 per month.	Additional $38.50 per month.	Additional $38.50 per month.
What you should know	N/A	The monthly premium is in addition to your monthly plan premium.		The monthly premium is in addition to your monthly plan 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.	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.
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.		• 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. If purchased, the Tufts Medicare Preferred Dental Option replaces the embedded dental benefit included with your plan.		Coverage is limited to providers within the Dominion PPO network. $1,000 calendar year maximum. No waiting period. Other benefit limits apply. If purchased, the Tufts Medicare Preferred Dental Option replaces the embedded dental benefit included with your plan (Value Rx and Value No Rx plans only).				

Additional Benefits	Tufts Medicare Preferred **HMO Smart Saver Rx**	Tufts Medicare Preferred **HMO Basic No Rx**	Tufts Medicare Preferred **HMO Basic Rx**	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								
Acupuncture services	$20 copay per visit	$20 copay per visit	$20 copay per visit	$20 copay per visit	$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. A referral may be required from your PCP before you receive these services. Your PCP will provide this referral if needed. Additional acupuncture services are eligible for reimbursement under the annual Wellness Allowance benefit (if applicable). See additional details under "Wellness Programs."			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. A referral may be required from your PCP before you receive these services. Your PCP will provide this referral if needed. 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	$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	$15 copay per visit	$15 copay per visit	$15 copay per visit	$15 copay per visit
What you should know	Prior authorization may be required. A referral may be required from your PCP before you receive these services. Your PCP will provide this referral if needed.			Prior authorization may be required. A referral may be required from your PCP before you receive these services. Your PCP will provide this referral if needed.				

Additional Benefits	Tufts Medicare Preferred **HMO Smart Saver Rx**	Tufts Medicare Preferred **HMO Basic No Rx**	Tufts Medicare Preferred **HMO Basic Rx**	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)								
Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions	$40 copay per visit	$40 copay per visit	$40 copay per visit	$25 copay per visit	$25 copay per visit	$15 copay per visit	$15 copay per visit	$15 copay per visit
What you should know	A referral may be required from your PCP before you receive these services. Your PCP will provide this referral if needed.			A referral may be required from your PCP before you receive these services. Your PCP will provide this referral if needed.				
Home Health Services								
Home health agency care	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Home infusion therapy	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
What you should know	Prior authorization may be required. A referral may be required from your PCP before you receive home health agency care. Your PCP will provide this referral if needed.			Prior authorization may be required. A referral may be required from your PCP before you receive home health agency care. Your PCP will provide this referral if needed.				
Hospice								
Hospice	Benefit provided by Medicare	Benefit provided by Medicare	Benefit provided by Medicare	Benefit provided by Medicare	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. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.			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. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.				
Medical Equipment/Supplies								
Durable medical equipment (e.g., wheelchairs, oxygen)	Region A: 0% of the cost for basic devices; 20% of the cost for moderate complexity devices; 50% of the cost for complex devices Region B: 0% of the cost for basic devices; 20% of the cost for moderate complexity devices; 50% of the cost for complex devices Region C: 20% of the cost	20% of the cost	20% of the cost	10% of the cost	10% of the cost	10% of the cost	10% of the cost	10% of the cost
What you should know	For Smart Saver Regions A and B ONLY: Basic devices are items that support basic mobility and daily living such as low-cost canes, crutches, wheelchair accessories, walkers, commodes, replacement parts and disposable items. Moderate complexity devices serve as primary therapy or treatment devices such as oxygen equipment and supplies, light weight non-standard wheelchairs, heavy duty non-standard wheelchairs, manual scooters, specialized mattresses, all other non-standard speech generating devices and nebulizers. Complex devices are for complex or long-term medical needs such as powered non-standard wheelchairs, powered scooters, specialized beds and tablets/PC/PDA-based speech generating devices. Prior authorization may be required.			Prior authorization may be required.				
Prosthetic devices (e.g., braces, artificial limbs, etc.)	20% of the cost	20% of the cost	20% of the cost	10% of the cost	10% of the cost	10% of the cost	10% of the cost	10% of the cost
What you should know	For Smart Saver Rx and HMO Basic No Rx ONLY: 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 Prior authorization may be required.			For Value No Rx, Prime No Rx, Prime Rx and Prime Rx Plus ONLY: 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 Prior authorization may be required.				
Wig allowance (for hair loss due to cancer treatment)	$500 per year	$500 per year	N/A	$500 per year	N/A	$500 per year	$500 per year	$500 per year
Diabetes services and supplies	$0 copay for Accu-Chek products manufactured by Roche Diabetes Care, Inc., Continuous Glucose Monitors (CGMs), and Diabetes self-management training. 20% of the cost for all other non-Accu-Chek products. For therapeutic shoes or inserts: Region A: 50% of the cost Region B: 50% of the cost Region C: 20% of the cost	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay

Additional Benefits	Tufts Medicare Preferred HMO Smart 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. Coverage for blood glucose monitors, blood glucose tests strips and control solutions are limited to the Accu-Chek products manufactured by Roche Diabetes Care, Inc. Please note that there is no preferred brand for lancets. Coverage for therapeutic Continuous Glucose Monitors (CGMs) is limited to Dexcom and FreeStyle Libre products that are considered Durable Medical Equipment (DME) by Medicare. Diabetic testing supplies, including test strips, lancets, glucose meters and CGMs are also covered at participating retail or mail-order pharmacies. Prior authorization may be required.		
Outpatient Substance Use Disorder Services			
Group or individual therapy visit	$30 copay per visit	$25 copay per visit	$25 copay per visit
Renal Dialysis			
Renal Dialysis	20% of the cost	20% of the cost	20% of the cost
Telehealth/Telemedicine Services			
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			
Weight Management program	The plan provides an annual Weight Management allowance towards program fees for weight loss programs such as WeightWatchers® or a hospital-based weight loss program. Region A: $150 Region B: $150 Region C: Not covered	The plan provides 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 plan provides an 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. Additional programs and items include alternative therapies, massage therapy, home fitness equipment, and fitness tracking devices and heart rate monitors (limit of one per year). Region A: $150 Region B: $150 Region C: Not covered	The plan provides 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. Additional programs and items include alternative therapies, massage therapy, home fitness equipment, and fitness tracking devices and heart rate monitors (limit of one per year).	
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. Coverage for blood glucose monitors, blood glucose tests strips and control solutions are limited to the Accu-Chek products manufactured by Roche Diabetes Care, Inc. Please note that there is no preferred brand for lancets. Coverage for therapeutic Continuous Glucose Monitors (CGMs) is limited to Dexcom and FreeStyle Libre products that are considered Durable Medical Equipment (DME) by Medicare. Diabetic testing supplies, including test strips, lancets, glucose meters and CGMs are also covered at participating retail or mail-order pharmacies. Prior authorization may be required.				
Outpatient Substance Use Disorder Services				
$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				
The plan provides a $150 annual Weight Management allowance towards program fees for weight loss programs such as WeightWatchers® or a hospital-based weight loss program.				
The plan provides 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. Additional programs and items include alternative therapies, massage therapy, home fitness equipment, and fitness tracking devices and heart rate monitors (limit of one per year).				
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

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, 2027, and may change during the year. Discounts and services included as value added items and services are not plan benefits and are not subject to the Medicare appeals process. 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.

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. Plus, programs and collections are always being added.

Independent Living

Be Safer at Home-Personal Emergency Response Systems (PERS)

Receive a discounted rate 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. BSAH has several options to meet your lifestyle and budget needs including; Landline, Cellular, Mobile, Mobile GPS and Fall Detection.

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 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.

Mom's Meals

Mom's Meals Affinity Program provides members with access to nutritious, home-delivered meals.

- Shipping included on all orders
- Meals last in the refrigerator for 14 days from delivery and are ready to heat, eat and enjoy in minutes
- Members conveniently order online or by phone

Value Added Items and Services

Personal Growth and Development

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 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

Save 25% on the provider's usual fee.

Acupuncture

Save 25% on the provider's usual fee.

Laser Vision Correction

Get 15% off the retail price, or 5% off the promotional price of LASIK and PRK laser vision correction.

Hearing Aids

Discounts are available through TruHearing on a wide selection of hearing aid choices from major manufacturers

- 2-year supply of batteries at no charge
- 1-year in-office servicing at no charge
- 3-year comprehensive warranty, including loss and damage
- 60-day hearing aid evaluation period
- Complete hearing aid evaluation at no charge
- No interest financing available for 12 months for qualified applicants

TUFTS Health Plan
a Point32Health company

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) or speak to your provider.

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) o hable con su proveedor.

Português (Portuguese) ATENÇÃO: Se fala Português, estão disponíveis para si serviços gratuitos de assistência linguística. Estão também disponíveis gratuitamente ajudas e serviços auxiliares adequados para fornecer informações em formatos acessíveis. Ligue para 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY - Dispositivo das telecomunicações para surdos: 711) ou fale com o seu prestador.

中文 (**Simplified Chinese**) 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-800-701-9000 (HMO)/1-866-623-0172 (PPO)（文本电话：711）或咨询您的服务提供商。

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) oswa pale avèk founisè w la.

Việt (Vietnamese) LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

РУССКИЙ (Russian) ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) или обратитесь к своему поставщику услуг.

(Arabic)العربية تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 711 (1-800-701-9000 (PPO) 1-866-623-0172/(HMO)) أو تحدث إلى مقدم الخدمة.

ភាសាខ្មែរ (**Khmer**) សូមយកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយ ភាសាខ្មែរ សេវាកម្មជំនួយភាសាឥតគិតថ្លៃគឺមានសម្រាប់អ្នក។ ជំនួយ និងសេវាកម្មដែលជាការជួយដ៏សមរម្យ ក្នុងការផ្តល់ព័ត៌មានតាមទម្រង់ដែលអាចចូលប្រើប្រាស់បាន ក៏អាចរកបានដោយឥតគិតថ្លៃផងដែរ។ ហៅទូរសព្ទទៅ 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) ឬនិយាយទៅកាន់អ្នកផ្តល់សេវារបស់អ្នក។

Français (French) ATTENTION: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) ou parlez à votre fournisseur.

Italiano (Italian) ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (tty: 711) o parla con il tuo fornitore.

한국어 **(Korean)** 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-701-9000 (HMO)/1-866-623-0172 (PPO)(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.

Ελληνικά (Greek) ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες υποστήριξης στη συγκεκριμένη γλώσσα. Διατίθενται δωρεάν κατάλληλα βοηθήματα και υπηρεσίες για παροχή πληροφοριών σε προσβάσιμες μορφές. Καλέστε το 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) ή απευθυνθείτε στον πάροχό σας.

POLSKI (Polish) UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) lub porozmawiaj ze swoim dostawcą.

हिंदी **(Hindi)**न दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

ગુજરાતી **(Gujarati)** ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

Y0065_2025_132_C

Questions

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

TUFTS Health Plan

1 Wellness Way
Canton, MA 02021

Tufts Health Plan is an HMO plan with a Medicare contract. Enrollment in Tufts Health Plan depends on contract renewal. Benefits eligibility requirements must be met. Not all may qualify. This information is not a complete description of benefits. Call 1-800-701-9000 (TTY: 711) for more information. The supplemental dental benefit is administered by Dominion Dental Services, Inc., which operates under the trade name Dominion National. Benefit limits apply. Cost share applies to non-preventive services. Services must be performed by providers in the Dominion PPO Network. Please refer to your Evidence of Coverage for more information including details for how to request a pre-treatment estimate and other limitations that apply. SilverSneakers is a registered trademark of Tivity Health, Inc. © 2026 Tivity Health, Inc. All rights reserved. Tufts Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex (including pregnancy, sexual orientation and gender identity). ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-701-9000 (TTY: 711).