TUFTS MEDICARE PREFERRED HMO PLANS | 2018

Summary of Benefits

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 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

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

Effective January 1, 2018–December 31, 2018
H2256_2018_5 Accepted

TUFTS Health Plan

SUMMARY OF BENEFITS
January 1, 2018 – December 31, 2018

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 plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on http://www.medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Things to Know About Tufts Medicare Preferred HMO

Hours of operation

- From October 1 to February 14, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern time.
- From February 15 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern time.

Tufts Medicare Preferred HMO phone numbers and website

- If you are a member of this plan, call toll-free 1-800-701-9000.
- If you are not a member of this plan, call toll-free 1-877-409-3499.
- Our website: tuftsmedicarepreferred.org

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 the providers that are not in our network, the plan may not pay for these services.

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

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

Referral Circles

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

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers - and more.

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

Tufts Medicare Preferred HMO Saver Rx, Tufts Medicare Preferred HMO Basic Rx, Tufts Medicare Preferred HMO Value Rx, Tufts Medicare Preferred HMO Prime Rx, and Tufts Medicare Preferred HMO Prime Rx Plus cover Part D drugs. 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, tuftsmedicarepreferred.org.
- Or, call us and we will send you a copy of the formulary.

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

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

	Tufts Medicare Preferred HMO Saver Rx	Tufts Medicare Preferred HMO Basic No Rx	Tufts Medicare Preferred HMO Basic Rx
Monthly Plan Premium			
Barnstable, Bristol, Middlesex, Norfolk & Plymouth	$0 per month.	Not offered.	$46.00 per month.
Essex & Suffolk	$0 per month.	$38.00 per month.	$66.00 per month.
Hampden & Hampshire	Not offered.	Not offered.	$24.00 per month.
Worcester	$0 per month.	$40.00 per month.	$68.00 per month.
What You Should Know	In addition, you must keep paying your Medicare Part B premium.		
Deductible ***(for Part D prescription drugs except for drugs listed on Tier 1 and Tier 2 which are excluded from the deductible)***			
	$400 per year	This plan does not cover prescription drugs.	$350 per year
Maximum Out-of-Pocket Responsibility ***(does not include prescription drugs)***			
	$4,500 annually	$3,400 annually	$3,400 annually
What You Should Know	Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums (and cost-sharing for your Part D prescription drugs if applicable).		
INPATIENT AND OUTPATIENT CARE AND SERVICES			
Inpatient Hospital			
	• $350 copay per day for days 1 through 5 • You pay nothing per day for days 6 through 90 • You pay nothing per day for days 91 and beyond	• $275 copay per day for days 1 through 5 • You pay nothing per day for days 6 through 90 • You pay nothing per day for days 91 and beyond	
What You Should Know	Our plan covers an unlimited number of days for an inpatient hospital stay.		
Outpatient Surgery			
Ambulatory surgical center	$350 copay per visit	$250 copay per visit	
Outpatient hospital	$350 copay per visit	$250 copay per visit	
What You Should Know	Before you receive services, you must obtain a referral from your PCP. Prior Authorization may be required.		

Tufts Medicare Preferred HMO Value No Rx	Tufts Medicare Preferred HMO Value Rx	Tufts Medicare Preferred HMO Prime No Rx	Tufts Medicare Preferred HMO Prime Rx	Tufts Medicare Preferred HMO Prime Rx Plus
$103.00 per month.	$132.00 per month.	$133.00 per month.	$166.00 per month.	$200.00 per month.
$123.00 per month.	$152.00 per month.	$156.00 per month.	$189.00 per month.	$221.00 per month.
$41.00 per month.	$70.00 per month.	$67.00 per month.	$100.00 per month.	$132.00 per month.
$112.00 per month.	$147.00 per month.	$152.00 per month.	$186.00 per month.	Not offered.

In addition, you must keep paying your Medicare Part B premium.

This plan does not cover prescription drugs.	$300 per year	This plan does not cover prescription drugs.	This plan does not have a deductible.	This plan does not have a deductible.
$3,400 annually	$3,400 annually	$3,400 annually	$3,400 annually	$3,400 annually

Like all Medicare health plans, our plan protects you
by having yearly limits on your out-of-pocket costs for medical and hospital care.

If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost 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).

• $200 copay per day for days 1 through 5 • You pay nothing per day for days 6 through 90 • You pay nothing per day for days 91 and beyond	• $300 copay per stay • You pay nothing per day for days 91 and beyond You will not pay more than $900 for inpatient hospital covered services in a calendar year.	• $200 copay per stay • You pay nothing per day for days 91 and beyond You will not pay more than $400 for inpatient hospital covered services in a calendar year.

Our plan covers an unlimited number of days for an inpatient hospital stay.

$150 copay per visit	$100 copay per visit	$75 copay per visit
$150 copay per visit	$100 copay per visit	$75 copay per visit

Before you receive services, you must obtain a referral from your PCP.
Prior Authorization may be required.

	Tufts Medicare Preferred HMO Saver Rx	Tufts Medicare Preferred HMO Basic No Rx	Tufts Medicare Preferred HMO Basic Rx
INPATIENT AND OUTPATIENT CARE AND SERVICES			
Doctor Visits			
Primary care physician	$0-20 copay per visit, depending on the service	$0-10 copay per visit, depending on the service	
Specialist	$45 copay per visit	$40 copay per visit	
What You Should Know	Before you receive services from a specialist, you must obtain a referral from your PCP.		
Preventive Care			
	You pay nothing	You pay nothing	
What You Should Know	Any additional preventive services approved by Medicare during the contract year will be covered.		
Emergency Care			
	$80 copay per visit	$100 copay per visit	
What You Should Know	If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. Your plan includes worldwide coverage for emergency care.		
Urgently Needed Services			
	$20-45 copay per visit, depending on the service	$10-40 copay per visit, depending on the service	
What You Should Know	Urgently needed care may be furnished by in-network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. Your plan includes worldwide coverage for urgently needed care.		
Diagnostic Services/Labs/Imaging			
Diagnostic radiology services *(such as MRIs, CT scans)*	$300 copay per day	$250 copay per day	
Diagnostic tests and procedures	$10 per day per provider	$10 per day per provider	
Lab services	$10 per day per provider	$10 per day per provider	
Outpatient X-rays	$10 per day per provider	$10 per day per provider	

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
$0-10 copay per visit, depending on the service		$0-10 copay per visit, depending on the service		
$25 copay per visit		$15 copay per visit		
Before you receive services from a specialist, you must obtain a referral from your PCP.				
You pay nothing		You pay nothing		
Any additional preventive services approved by Medicare during the contract year will be covered.				
$100 copay per visit		$100 copay per visit		
If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. Your plan includes worldwide coverage for emergency care.				
$10-25 copay per visit, depending on the service		$10-15 copay per visit, depending on the service		
Urgently needed care may be furnished by in-network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. Your plan includes worldwide coverage for urgently needed care.				
$100 copay per day		20% of the cost You will not pay more than $75 per day for diagnostic radiology services.		
$5 per day per provider		You pay nothing		
$5 per day per provider		You pay nothing		
$5 per day per provider		You pay nothing		

	Tufts Medicare Preferred HMO Saver Rx	Tufts Medicare Preferred HMO Basic No Rx	Tufts Medicare Preferred HMO Basic Rx
INPATIENT AND OUTPATIENT CARE AND SERVICES			
Hearing Services			
Exam to diagnose and treat hearing and balance issues	$45 copay per visit	$40 copay per visit	
Routine hearing exam *(for up to 1 every year)*	$45 copay per visit	$40 copay per visit	
Hearing Aids	Not covered	Not covered	
What You Should Know	Before you receive a diagnostic hearing exam from a specialist, you must obtain a referral from your PCP.		
Dental Services			
	$45 copay per visit	$40 copay per visit	
What You Should Know	Limited dental services (this does not include preventive dental services such as cleaning, routine dental exams, and dental x-rays)		
Vision Services			
Routine eye exam *(for up to 1 every year)*	$45 copay per visit	$40 copay per visit	
Exam to diagnose and treat diseases and conditions of the eye *(including yearly glaucoma screening)*	$0 - 45 copay per visit, depending on the service	$0 - 40 copay per visit, depending on the service	
Annual eyewear benefit	Up to $150 allowance per calendar year	Up to $150 allowance per calendar year	
What You Should Know	You must use a participating Vision Care provider (EyeMed Vision Care) to receive the covered Routine Eye Exam benefit. You must purchase your glasses or contacts from a participating vision provider (EyeMed Vision Care) to receive the $150 allowance. Otherwise, the benefit will be limited to $90 per year.		

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
$25 copay per visit		$15 copay per visit		
$25 copay per visit		$15 copay per visit		
Hearing aid allowance of $500 every three years		Hearing aid allowance of $500 every three years		
Before you receive a diagnostic hearing exam from a specialist, you must obtain a referral from your PCP.				
$25 copay per visit		$15 copay per visit		
Limited dental services (this does not include preventive dental services such as cleaning, routine dental exams, and dental x-rays)				
$25 copay per visit		$15 copay per visit		
$0 - 25 copay per visit, depending on the service		$0 - 15 copay per visit, depending on the service		
Up to $150 allowance per calendar year		Up to $150 allowance per calendar year		
You must use a participating Vision Care provider (EyeMed Vision Care) to receive the covered Routine Eye Exam benefit. You must purchase your glasses or contacts from a participating vision provider (EyeMed Vision Care) to receive the $150 allowance. Otherwise, the benefit will be limited to $90 per year.				

	Tufts Medicare Preferred HMO Saver Rx	Tufts Medicare Preferred HMO Basic No Rx	Tufts Medicare Preferred HMO Basic Rx
INPATIENT AND OUTPATIENT CARE AND SERVICES			
Mental Health Services			
Inpatient visit	• $315 copay per day for days 1 through 5 • You pay nothing per day for days 6 through 90	• $275 copay per day for days 1 through 5 • You pay nothing per day for days 6 through 90	
Outpatient group or individual therapy visit	$40 copay per visit	$40 copay per visit	
What You Should Know	Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. Before you receive outpatient group or individual therapy visits, you must obtain a referral from your PCP.		
Skilled Nursing Facility (SNF)			
	• $0 copay per day for days 1 through 20 • $160 copay per day for days 21 through 44 • $0 copay per day for days 45 through 100	• $20 copay per day for days 1 through 20 • $140 copay per day for days 21 through 44 • $0 copay per day for days 45 through 100	
What You Should Know	Our plan covers up to 100 days in a SNF.		
Physical Therapy			
Occupational therapy	$40 copay per visit	$30 copay per visit	
Physical therapy and speech and language therapy	$40 copay per visit	$30 copay per visit	
What You Should Know	Before you receive occupational therapy, physical therapy, or speech and language therapy services, you must obtain a referral from your PCP.		
Ambulance			
	$300 copay per day	$275 copay per day	
Transportation			
	Not covered	Not covered	

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
• $200 copay per day for days 1 through 5 • You pay nothing per day for days 6 through 90		$300 copay per stay You will not pay more than $900 for inpatient hospital covered services in a calendar year.		$200 copay per day You will not pay more than $400 for inpatient hospital covered services in a calendar year.
$25 copay per visit		$15 copay per visit		
Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. Before you receive outpatient group or individual therapy visits, you must obtain a referral from your PCP.				
• $20 copay per day for days 1 through 20 • $100 copay per day for days 21 through 44 • $0 copay per day for days 45 through 100		• $20 copay per day for days 1 through 20 • $60 copay per day for days 21 through 44 • $0 copay per day for days 45 through 100		• $20 copay per day for days 1 through 20 • $0 copay per day for days 21 through 100
Our plan covers up to 100 days in a SNF.				
$20 copay per visit		$15 copay per visit		
$20 copay per visit		$15 copay per visit		
Before you receive occupational therapy, physical therapy, or speech and language therapy services, you must obtain a referral from your PCP.				
$225 copay per day		$125 copay per day	$125 copay per day	$90 copay per day
Not covered		Not covered		

	Tufts Medicare Preferred HMO Saver Rx	Tufts Medicare Preferred HMO Basic No Rx	Tufts Medicare Preferred HMO Basic Rx
INPATIENT AND OUTPATIENT CARE AND SERVICESS			
Medicare Part B Drugs			
	For Part B drugs such as chemotherapy drugs: You pay 20% of the cost Other Part B drugs: You pay 20% of the cost	For Part B drugs such as chemotherapy drugs: You pay nothing Other Part B drugs: You pay nothing	
PRESCRIPTION DRUG BENEFITS			
Initial Coverage			
	After you pay your yearly $400 deductible, you pay the following until your total yearly drug costs reach $3,750. 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 $350 deductible, you pay the following until your total yearly drug costs reach $3,750. 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
For Part B drugs such as chemotherapy drugs: You pay nothing Other Part B drugs: You pay nothing		For Part B drugs such as chemotherapy drugs: You pay nothing Other Part B drugs: You pay nothing		
This plan does not cover Part D prescription drugs	After you pay your yearly $300 deductible, you pay the following until your total yearly drug costs reach $3,750. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.	This plan does not cover Part D prescription drugs	You pay the following until your total yearly drug costs reach $3,750. 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 Saver Rx			Tufts Medicare Preferred HMO Basic Rx		
PRESCRIPTION DRUG BENEFITS						
Initial Coverage						
Standard Retail Cost-Sharing						
Tier	**One-month supply**	**Two-month supply**	**Three-month supply**	**One-month supply**	**Two-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	$6 copay	$12 copay	$18 copay	$4 copay	$8 copay	$12 copay
Tier 2 (Generic)	$12 copay	$24 copay	$36 copay	$8 copay	$16 copay	$24 copay
Tier 3 (Preferred Brand)	$47 copay	$94 copay	$141 copay	$47 copay	$94 copay	$141 copay
Tier 4 (Non-Preferred Drug)	$100 copay	$200 copay	$300 copay	$100 copay	$200 copay	$300 copay
Tier 5 (Specialty Tier)	25% of the cost	N/A	N/A	26% of the cost	N/A	N/A
Standard Mail Order Cost-Sharing						
Tier	**One-month supply**	**Two-month supply**	**Three-month supply**	**One-month supply**	**Two-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	$6 copay	$12 copay	$12 copay	$4 copay	$8 copay	$8 copay
Tier 2 (Generic)	$12 copay	$24 copay	$24 copay	$8 copay	$16 copay	$16 copay
Tier 3 (Preferred Brand)	$47 copay	$94 copay	$94 copay	$47 copay	$94 copay	$94 copay
Tier 4 (Non-Preferred Drug)	$100 copay	$200 copay	$300 copay	$100 copay	$200 copay	$300 copay
Tier 5 (Specialty Tier)	25% of the cost	N/A	N/A	26% of the cost	N/A	N/A
	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 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 and Tier 2 drugs and you pay your share of the cost. After you have met your annual $400 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 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 and Tier 2 drugs and you pay your share of the cost. After you have met your annual $350 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		
One-month supply	Two-month supply	Three-month supply	One-month supply	Two-month supply	Three-month supply	One-month supply	Two-month supply	Three-month supply
$4 copay	$8 copay	$12 copay	$4 copay	$8 copay	$12 copay	$2 copay	$4 copay	$6 copay
$8 copay	$16 copay	$24 copay	$8 copay	$16 copay	$24 copay	$4 copay	$8 copay	$12 copay
$47 copay	$94 copay	$141 copay	$47 copay	$94 copay	$141 copay	$30 copay	$60 copay	$90 copay
$100 copay	$200 copay	$300 copay	$100 copay	$200 copay	$300 copay	$80 copay	$160 copay	$240 copay
27% of the cost	N/A	N/A	33% of the cost	N/A	N/A	33% of the cost	N/A	N/A
One-month supply	Two-month supply	Three-month supply	One-month supply	Two-month supply	Three-month supply	One-month supply	Two-month supply	Three-month supply
$4 copay	$8 copay	$8 copay	$4 copay	$8 copay	$8 copay	$2 copay	$4 copay	$4 copay
$8 copay	$16 copay	$16 copay	$8 copay	$16 copay	$16 copay	$4 copay	$8 copay	$8 copay
$47 copay	$94 copay	$94 copay	$47 copay	$94 copay	$94 copay	$30 copay	$60 copay	$60 copay
$100 copay	$200 copay	$300 copay	$100 copay	$200 copay	$300 copay	$80 copay	$160 copay	$240 copay
27% of the cost	N/A	N/A	33% of the cost	N/A	N/A	33% of the cost	N/A	N/A
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 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 and Tier 2 drugs and you pay your share of the cost. After you have met your annual $300 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 may pay more than you pay at an in-network pharmacy.			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 may pay more than you pay at an in-network pharmacy.		

	Tufts Medicare Preferred HMO Saver Rx	Tufts Medicare Preferred HMO Basic Rx
PRESCRIPTION DRUG BENEFITS		
Coverage Gap		
	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,750. After you enter the coverage gap, you pay 35% of the plan's cost for covered brand name drugs and 44% of the plan's cost for covered generic drugs until your costs total $5,000, which is the end of the coverage gap. Not everyone will enter the coverage gap.	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,750. After you enter the coverage gap, you pay 35% of the plan's cost for covered brand name drugs and 44% of the plan's cost for covered generic drugs until your costs total $5,000, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Tufts Medicare Preferred HMO Value Rx	Tufts Medicare Preferred HMO Prime Rx	Tufts Medicare Preferred HMO Prime Rx Plus
Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,750. After you enter the coverage gap, you pay 35% of the plan's cost for covered brand name drugs and 44% of the plan's cost for covered generic drugs until your costs total $5,000, which is the end of the coverage gap. Not everyone will enter the coverage gap.	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,750. After you enter the coverage gap, you pay 35% of the plan's cost for covered brand name drugs and 44% of the plan's cost for covered generic drugs until your costs total $5,000, which is the end of the coverage gap. Not everyone will enter the coverage gap.	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,750. After you enter the coverage gap, you pay 35% of the plan's cost for covered brand name drugs and 44% of the plan's cost for covered generic drugs until your costs total $5,000, which is the end of the coverage gap. Not everyone will enter the coverage gap. Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out how much it will cost you.

	Tufts Medicare Preferred HMO Saver Rx	Tufts Medicare Preferred HMO Basic Rx
PRESCRIPTION DRUG BENEFITS		
Coverage Gap		
Catastrophic Coverage		
	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,000, you pay the greater of: • 5% of the cost, or • $3.35 copay for generic (including brand drugs treated as generic) and a $8.35 copayment for all other drugs.	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,000, you pay the greater of: • 5% of the cost, or • $3.35 copay for generic (including brand drugs treated as generic) and a $8.35 copayment for all other drugs.

Tufts Medicare Preferred HMO Value Rx	Tufts Medicare Preferred HMO Prime Rx	Tufts Medicare Preferred HMO Prime Rx Plus
		Standard Retail Cost-Sharing

Drug Covered	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)			
All	$2 Copay	$4 Copay	$6 Copay
Tier 2 (Generic)			
All	$4 Copay	$8 Copay	$12 Copay

Standard Mail Order Cost-Sharing

Drug Covered	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)			
All	$2 Copay	$4 Copay	$4 Copay
Tier 2 (Generic)			
All	$4 Copay	$8 Copay	$8 Copay

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5.000, you pay the greater of: • 5% of the cost, or • $3.35 copay for generic (including brand drugs treated as generic) and a $8.35 copayment for all other drugs.	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,000, you pay the greater of: • 5% of the cost, or • $3.35 copay for generic (including brand drugs treated as generic) and a $8.35 copayment for all other drugs.	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,000, you pay the greater of: • 5% of the cost, or • $3.35 copay for generic (including brand drugs treated as generic) and a $8.35 copayment for all other drugs.

	Tufts Medicare Preferred HMO Saver Rx	Tufts Medicare Preferred HMO Basic No Rx	Tufts Medicare Preferred HMO Basic Rx
OPTIONAL BENEFITS (You must pay an extra premium each month for these benefits)			
Delta Dental Option			
	Benefits include: • Preventive Dental • Comprehensive Dental	Benefits include: • Preventive Dental • Comprehensive Dental	
Monthly Premium			
	Additional $54.00 per month.	Additional $54.00 per month.	
What You Should Know	You must keep paying your Medicare Part B premium and your monthly plan premium.		
Deductible			
	$50 per year	$50 per year	
The Plan offers the following benefits:			
	• Preventive services covered at 100%. • Fillings, extractions, root canals covered at 80%.You pay 20% after deductible. **A 6 month waiting period applies**. • Dentures and crowns covered at 50%. You pay 50% after deductible. **A 6 month waiting period applies**.	• Preventive services covered at 100%. • Fillings, extractions, root canals covered at 80%.You pay 20% after deductible. **A 6 month waiting period applies**. • Dentures and crowns covered at 50%. You pay 50% after deductible. **A 6 month waiting period applies**.	
ADDITIONAL BENEFITS			
Acupuncture			
Acupuncture services when provided by a licensed acupuncturist	Acupuncture services are eligible for reimbursement under the annual Wellness Allowance benefit. See additional details under "Wellness Programs".		

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
Benefits include: • Preventive Dental • Comprehensive Dental		Benefits include: • Preventive Dental • Comprehensive Dental		
Additional $54.00 per month.		Additional $54.00 per month.		
You must keep paying your Medicare Part B premium and your monthly plan premium.				
$50 per year		$50 per year		
• Preventive services covered at 100%. • Fillings, extractions, root canals covered at 80%.You pay 20% after deductible. **A 6 month waiting period applies**. • Dentures and crowns covered at 50%. You pay 50% after deductible. **A 6 month waiting period applies**.		• Preventive services covered at 100%. • Fillings, extractions, root canals covered at 80%.You pay 20% after deductible. **A 6 month waiting period applies**. • Dentures and crowns covered at 50%. You pay 50% after deductible. **A 6 month waiting period applies**.		
Acupuncture services are eligible for reimbursement under the annual Wellness Allowance benefit. See additional details under “Wellness Programs”.				

	Tufts Medicare Preferred HMO Saver Rx	Tufts Medicare Preferred HMO Basic No Rx	Tufts Medicare Preferred HMO Basic Rx
ADDITIONAL BENEFITS			
Chiropractic Care			
Manipulation of the spine to correct a subluxation *(when 1 or more of the bones of your spine move out of position)*	$15 copay per visit	$15 copay per visit	
What You Should Know	Initial evaluation is covered once per year with $15 copay. Before you receive services from a specialist, you must obtain a referral from your PCP.		
Foot Care (*podiatry services)*			
Foot exams and treatment if you have diabetes-related nerve damage and/ or meet certain conditions	$45 copay per visit	$40 copay per visit	
What You Should Know	Before you receive services from a specialist, you must obtain a referral from your PCP.		
Home Health Services			
Home Health Agency Care	You pay nothing	You pay nothing	
Home Health Physical Therapy Services	You pay nothing	$30 copay per visit	
Hospice			
	You pay nothing	You pay nothing	
What You Should Know	You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.		

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
$15 copay per visit		$15 copay per visit		
Initial evaluation is covered once per year with $15 copay. Before you receive services from a specialist, you must obtain a referral from your PCP.				
$25 copay per visit		$15 copay per visit		
Before you receive services from a specialist, you must obtain a referral from your PCP.				
You pay nothing		You pay nothing		
$20 copay per visit		$15 copay per visit		You pay nothing
You pay nothing		You pay nothing		
You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.				

	Tufts Medicare Preferred HMO Saver Rx	Tufts Medicare Preferred HMO Basic No Rx	Tufts Medicare Preferred HMO Basic Rx
INPATIENT AND OUTPATIENT CARE AND SERVICES			
Medical Equipment/Supplies			
Durable Medical Equipment *(e.g., wheelchairs, oxygen)*	20% of the cost	20% of the cost	
Prosthetic Devices *(braces, artificial limbs, etc.)*	20% of the cost	20% of the cost	
Diabetes Services and Supplies	You pay nothing	You pay nothing	
What You Should Know	Items covered by the plan: bathroom safety equipment for members who have a functional impairment when having the item will improve safety: • Standard raised toilet seat: 1 per member every five years • Standard bathroom grab bars: 2 per member every five years • Standard tub seat: 1 per member every five years The following additional items are covered by the plan: • Gradient compression stockings or surgical stockings: up to 2 pair every 6 months • Mastectomy sleeves for members with upper limb lymphedema: up to 2 pair every 6 months • Wigs for members who experience hair loss due to cancer treatment: up to $500 per calendar year Includes diabetes monitoring supplies, diabetes self-management training, and therapeutic shoes or inserts. Copay may apply if you receive other medical services during the same office visit. Referral required for diabetes self-management training only. Coverage for blood glucose monitors, blood glucose tests strips, and glucose-control solutions is limited to the One Touch products manufactured by Lifescan, Inc. Please note that there is no preferred brand for lancets. Prior authorization may be required		
Outpatient Substance Abuse			
Group or individual therapy visit	$40 copay per visit	$40 copay per visit	
What You Should Know	Before you receive services from a specialist, you must obtain a referral from your PCP.		
Renal Dialysis			
	You pay nothing	You pay nothing	

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
10% of the cost		10% of the cost		
10% of the cost		10% of the cost		
You pay nothing		You pay nothing		

Items covered by the plan: bathroom safety equipment for members who have a functional impairment when having the item will improve safety:
- Standard raised toilet seat: 1 per member every five years
- Standard bathroom grab bars: 2 per member every five years
- Standard tub seat: 1 per member every five years

The following additional items are covered by the plan:
- Gradient compression stockings or surgical stockings: up to 2 pair every 6 months
- Mastectomy sleeves for members with upper limb lymphedema: up to 2 pair every 6 months
- Wigs for members who experience hair loss due to cancer treatment: up to $500 per calendar year

Includes diabetes monitoring supplies, diabetes self-management training, and therapeutic shoes or inserts. Copay may apply if you receive other medical services during the same office visit. Referral required for diabetes self-management training only.

Coverage for blood glucose monitors, blood glucose tests strips, and glucose-control solutions is limited to the One Touch products manufactured by Lifescan, Inc. Please note that there is no preferred brand for lancets.

Prior authorization may be required

$25 copay per visit		$15 copay per visit		

Before you receive services from a specialist, you must obtain a referral from your PCP.

You pay nothing		You pay nothing		

	Tufts Medicare Preferred HMO Saver Rx	Tufts Medicare Preferred HMO Basic No Rx	Tufts Medicare Preferred HMO Basic Rx
INPATIENT AND OUTPATIENT CARE AND SERVICES			
Wellness Programs			
Weight Management Program	The plan provides a $150 annual weight management allowance towards program fees for weight loss programs such as WeightWatchers, Jenny Craig, iDiet, or a hospital-based weight loss program.		
Wellness Allowance	The plan provides a $250 annual wellness allowance toward health club memberships, nutritional counseling, acupuncture, or fitness classes like Pilates, Tai Chi, or aerobics, and wellness programs, including memory fitness activities.	The 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.	
Healthways SilverSneakers®	**Applicable to residents of Worcester County only. Not Applicable to Tufts Medicare Preferred HMO Saver Rx.**		
	SilverSneakers encourages physical activity by offering access to classes, exercise equipment, and other amenities. Members receive a basic fitness membership and access to over 11,000 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
The plan provides a $150 annual weight management allowance towards program fees for weight loss programs such as WeightWatchers, Jenny Craig, iDiet, 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.				
Applicable to residents of Worcester County only. Not Applicable to Tufts Medicare Preferred HMO Saver Rx.				
SilverSneakers encourages physical activity by offering access to classes, exercise equipment, and other amenities. Members receive a basic fitness membership and access to over 11,000 participating locations. SilverSneakers offers different ways to get the activity you need to stay healthy.				

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

Tufts Health Plan:

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

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

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

Tufts Health Plan, Attention:

Civil Rights Coordinator, Legal Dept.
705 Mount Auburn St. Watertown, MA 02472
Phone: 1-888-880-8699 ext. 48000, (TTY number—711 or 1-800-439-2370. Español: 866-930-9252)
Fax: 617-972-9048
Email: OCRCoordinator@tufts-health.com.

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

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

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

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

thpmp.org | 1-800-701-9000

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Navajo: Díí baa akó nínízin: Díí saad bee yáníltı'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, koji' hódíílnih 1800-701-9000 (TTY: 711.)

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

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

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

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

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

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

QUESTIONS?

Call 1-877-409-3499 // TTY 711

Representatives are available Monday – Friday, 8 a.m. – 8 p.m. (From October 1 – February 14, representatives are available 7 days a week, 8 a.m. – 8 p.m.). After hours and on holidays, please leave a message and a representative will return your call on the next business day.

VISIT US AT: www.thpmp.org

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

This information is not a complete description of benefits. Contact the plan for more information.

Limitations, copayments, and restrictions may apply.

Benefits, premiums and/or co-payments/co-insurance may change on January 1 of each year.

TUFTS Health Plan

705 Mount Auburn Street,
Watertown, MA 02472