TUFTS Health Plan

2021 Summary of Benefits

Tufts Health Plan 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 Health Plan Medicare Preferred HMO Saver Rx
Tufts Health Plan Medicare Preferred HMO Basic No Rx
Tufts Health Plan Medicare Preferred HMO Basic Rx
Tufts Health Plan Medicare Preferred HMO Value No Rx
Tufts Health Plan Medicare Preferred HMO Value Rx
Tufts Health Plan Medicare Preferred HMO Prime No Rx
Tufts Health Plan Medicare Preferred HMO Prime Rx
Tufts Health Plan 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 visit **www.thpmp.org** to view the *Evidence of Coverage.* You can also request a printed copy by calling Customer Relations at 1-800-701-9000 (TTY: 711).

Effective January 1, 2021–December 31, 2021

H2256_2021_8_M

Summary of Benefits January 1, 2021–December 31, 2021

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as Tufts Health Plan Medicare Preferred HMO).

Tips for comparing your Medicare choices

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

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on **www.medicare.gov**.
- 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 Health Plan Medicare Preferred HMO

Who can join?

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

The service area for the 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 Health Plan Medicare Preferred HMO has a network of doctors, hospitals, pharmacies, and other providers. If you use providers that are not in our network, the plan may not pay for these services.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. You can see our plan's *Provider Directory* and *Pharmacy Directory* at our website (**www.thpmp.org**).

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

Referral circles

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

What do we cover?

We cover everything that Original Medicare covers—and more.

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

Tufts Health Plan Medicare Preferred HMO Saver Rx, Tufts Health Plan Medicare Preferred HMO Basic Rx, Tufts Health Plan Medicare Preferred HMO Value Rx, Tufts Health Plan Medicare Preferred HMO Prime Rx, and Tufts Health Plan 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, **www.thpmp.org**.

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

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

	Tufts Health Plan Medicare Preferred **HMO Saver Rx**	Tufts Health Plan Medicare Preferred **HMO Basic No Rx**	Tufts Health Plan Medicare Preferred **HMO Basic Rx**
Monthly Plan Premium			
Middlesex, Norfolk, Plymouth, Barnstable, Bristol	$0 per month	Not offered	$46 per month
Essex, Suffolk	$0 per month	$28 per month	$61 per month
Hampden, Hampshire	$0 per month	Not offered	$35 per month
Worcester	$0 per month	$20 per month	$43 per month
What You Should Know	In addition, you must keep paying your Medicare Part B premium.		
Deductible (for Part D prescription drugs)	$250 per year for your Tier 3, Tier 4, and Tier 5 drugs	This plan does not cover prescription drugs.	$225 per year for your Tier 3, Tier 4, and Tier 5 drugs
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$7,550	$3,450	
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, 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 Health Plan Medicare Preferred **HMO Saver Rx**	Tufts Health Plan Medicare Preferred **HMO Basic No Rx**	Tufts Health Plan Medicare Preferred **HMO Basic Rx**
Inpatient Hospital Care			
Inpatient hospital care	• $350 copay per day for days 1 through 5 • You pay nothing for days 6 through 90 • You pay nothing for days 91 and beyond	• $275 copay per day for days 1 through 5 • You pay nothing for days 6 through 90 • You pay nothing for days 91 and beyond	
What You Should Know	Our plan covers an unlimited number of days for an inpatient hospital stay. Prior authorization may be required.		
Outpatient Hospital Care			
Outpatient hospital services	$350 copay per day	$250 copay per day	
Outpatient surgery (services provided at hospital outpatient facilities and ambulatory surgical centers)	Colonoscopies: $0 Others: $350 copay per day	Colonoscopies: $0 Others: $250 copay per day	
What You Should Know	Before you receive services, you must obtain a referral from your PCP. Prior authorization may be required.		

Tufts Health Plan Medicare Preferred **HMO Value No Rx**	Tufts Health Plan Medicare Preferred **HMO Value Rx**	Tufts Health Plan Medicare Preferred **HMO Prime No Rx**	Tufts Health Plan Medicare Preferred **HMO Prime Rx**	Tufts Health Plan Medicare Preferred **HMO Prime Rx Plus**
Monthly Plan Premium				
$103 per month	$150 per month	$133 per month	$180 per month	$214 per month
$123 per month	$170 per month	$156 per month	$203 per month	$235 per month
Not offered	$73 per month	Not offered	$98 per month	$118 per month
$112 per month	$160 per month	$152 per month	$195 per month	Not offered
In addition, you must keep paying your Medicare Part B premium.				
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.
$3,450		$3,450		
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, we will pay the full cost of your covered hospital and medical services for the rest of the year. Please note that you will still need to pay your monthly premiums (and cost-sharing for your Part D prescription drugs if applicable).				

Tufts Health Plan Medicare Preferred **HMO Value No Rx**	Tufts Health Plan Medicare Preferred **HMO Value Rx**	Tufts Health Plan Medicare Preferred **HMO Prime No Rx**	Tufts Health Plan Medicare Preferred **HMO Prime Rx**	Tufts Health Plan Medicare Preferred **HMO Prime Rx Plus**
Inpatient hospital care				
• $200 copay per day for days 1 through 5 • You pay nothing for days 6 through 90 • You pay nothing for days 91 and beyond		• $300 copay per stay • You will not pay more than $900 for inpatient hospital covered services in a calendar year.		• $200 copay per stay • You will not pay more than $400 for inpatient hospital covered services in a calendar year.
Our plan covers an unlimited number of days for an inpatient hospital stay. Prior authorization may be required.				
Outpatient hospital care				
$150 copay per day		$100 copay per day		$75 copay per day
Colonoscopies: $0 Others: $150 copay per day		Colonoscopies: $0 Others: $100 copay per day		Colonoscopies: $0 Others: $75 copay per day
Before you receive services, you must obtain a referral from your PCP. Prior authorization may be required.				

Inpatient and Outpatient Care and Services	Tufts Health Plan Medicare Preferred **HMO Saver Rx**	Tufts Health Plan Medicare Preferred **HMO Basic No Rx**	Tufts Health Plan Medicare Preferred **HMO Basic Rx**
Doctor Visits			
Primary care physician	$10 copay per visit	$10 copay per visit	
Specialist	$45 copay per visit	$40 copay per visit	
What You Should Know	There is no copay for an annual physical exam with your PCP. 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	$90 copay per visit	$110 copay per visit	
What You Should Know	If you are admitted to the hospital within 24 hours for the same condition, you do not have to pay your share of the cost for emergency care. Your plan includes worldwide coverage for emergency care.		
Urgently needed services	$10 copay per PCP visit $45 copay per Specialist visit	$10 copay per PCP visit $40 copay per Specialist visit	
What You Should Know	Urgently needed care may be furnished by in-network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. Copayment is not waived if admitted as an inpatient within 24 hours. Your plan includes worldwide coverage for urgently needed care.		
Diagnostic Services/Labs/Imaging			
Diagnostic radiology services (such as MRIs, CT scans)	$325 copay per day $100 per day for ultrasound	$250 copay per day $100 per day for ultrasound	
Diagnostic tests and procedures	$10 per day	$10 per day	
Lab services	FIT tests: $0 Others: $10 per day	FIT tests: $0 Others: $10 per day	
Outpatient X-rays	$10 per day	$10 per day	
What You Should Know	No copay for diagnostic tests and procedures, lab services, and outpatient X-rays if the services are performed as part of an office visit. Prior authorization may be required.		
Hearing Services			
Exam to diagnose and treat hearing and balance issues	$45 copay per visit	$40 copay per visit	
Routine hearing exam (up to 1 every year)	$45 copay per visit	$40 copay per visit	
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		

Tufts Health Plan Medicare Preferred **HMO Value No Rx**	Tufts Health Plan Medicare Preferred **HMO Value Rx**	Tufts Health Plan Medicare Preferred **HMO Prime No Rx**	Tufts Health Plan Medicare Preferred **HMO Prime Rx**	Tufts Health Plan Medicare Preferred **HMO Prime Rx Plus**
Doctor Visits				
$10 copay per visit		$10 copay per visit		
$25 copay per visit		$15 copay per visit		
There is no copay for an annual physical exam with your PCP. 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.				
$110 copay per visit		$110 copay per visit		
If you are admitted to the hospital within 24 hours for the same condition, you do not have to pay your share of the cost for emergency care. Your plan includes worldwide coverage for emergency care.				
$10 copay per PCP visit $25 copay per Specialist visit		$10 copay per PCP visit $15 copay per Specialist visit		
Urgently needed care may be furnished by in-network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. Copayment is not waived if admitted as an inpatient within 24 hours. Your plan includes worldwide coverage for urgently needed care.				
Diagnostic Services/Labs/Imaging				
$100 copay per day		20% of the cost You will not pay more than $75 per day for diagnostic radiology services.		
$5 per day		You pay nothing		
FIT tests: $0 Others: $5 per day		You pay nothing		
$5 per day		You pay nothing		
No copay for diagnostic tests and procedures, lab services, and outpatient X-rays if the services are performed as part of an office visit. Prior authorization may be required.				
Hearing Services				
$25 copay per visit		$15 copay per visit		
$25 copay per visit		$15 copay per visit		
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				

Inpatient and Outpatient Care and Services	Tufts Health Plan Medicare Preferred **HMO Saver Rx**	Tufts Health Plan Medicare Preferred **HMO Basic No Rx**	Tufts Health Plan Medicare Preferred **HMO Basic Rx**	Tufts Health Plan Medicare Preferred **HMO Value No Rx**	Tufts Health Plan Medicare Preferred **HMO Value Rx**	Tufts Health Plan Medicare Preferred **HMO Prime No Rx**	Tufts Health Plan Medicare Preferred **HMO Prime Rx**	Tufts Health Plan Medicare Preferred **HMO Prime Rx Plus**
What You Should Know	Before you receive a diagnostic hearing exam from a specialist, you must obtain a referral from your PCP. You must purchase hearing aids through Hearing Care Solutions to receive the Hearing Aid benefit. Up to 2 hearing aids per year, 1 hearing aid per ear. Hearing aid fitting is provided by Hearing Care Solutions at no cost.			Before you receive a diagnostic hearing exam from a specialist, you must obtain a referral from your PCP. You must purchase hearing aids through Hearing Care Solutions to receive the Hearing Aid benefit. Up to 2 hearing aids per year, 1 hearing aid per ear. Hearing aid fitting is provided by Hearing Care Solutions at no cost.				
Dental								
Limited Medicare-covered dental services	$45 copay per visit	$40 copay per visit		$25 copay per visit	$15 copay per visit			
What You Should Know	Limited Medicare-covered dental services do not include preventive dental services such as cleaning, routine dental exams, and dental X-rays.			Limited Medicare-covered dental services do not include preventive dental services such as cleaning, routine dental exams, and dental X-rays.				
Embedded dental benefit	$1,000 calendar year maximum. $0 for preventive services such as cleaning and oral exams, and 50% coinsurance for restorative services such as fillings and simple extractions. No deductible. No waiting period.			Not covered	Not covered			
What You Should Know	Coverage is limited to providers within the Dominion PPO network.			N/A				
Tufts Health Plan Medicare Preferred Dental Option	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			
Exam to diagnose and treat diseases and conditions of the eye	$45 copay per visit	$40 copay per visit		$25 copay per visit	$15 copay per visit			
Annual glaucoma screening	$0 copay per visit	$0 copay per visit		$0 copay per visit	$0 copay per visit			
Annual eyewear benefit	Up to $150 allowance per calendar year	Up to $150 allowance per calendar year		Up to $150 allowance per calendar year	Up to $150 allowance per calendar year			
What You Should Know	You must use a participating vision care provider (EyeMed Vision Care) to receive the covered Routine Eye Exam benefit. You must purchase your glasses, frames, prescription lenses, or contacts from a participating vision provider (EyeMed Vision Care) to receive the $150 allowance. Otherwise, the benefit will be limited to $90 per year. You need a referral from your PCP for a diagnostic eye exam.			You must use a participating vision care provider (EyeMed Vision Care) to receive the covered Routine Eye Exam benefit. You must purchase your glasses, frames, prescription lenses, or contacts from a participating vision provider (EyeMed Vision Care) to receive the $150 allowance. Otherwise, the benefit will be limited to $90 per year. You need a referral from your PCP for a diagnostic eye exam.				
Mental Health Services								
Inpatient visit	$315 copay per day for days 1 through 5. You pay nothing for days 6 through 90.	$275 copay per day for days 1 through 5. You pay nothing for days 6 through 90.		$200 copay per day for days 1 through 5. You pay nothing 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 stay. You will not pay more than $400 for inpatient hospital covered services in a calendar year.
Outpatient group or individual therapy visit	$25 copay per visit	$25 copay per visit		$20 copay per visit	$10 copay per visit			

Inpatient and Outpatient Care and Services	Tufts Health Plan Medicare Preferred **HMO Saver Rx**	Tufts Health Plan Medicare Preferred **HMO Basic No Rx**	Tufts Health Plan Medicare Preferred **HMO Basic Rx**
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 health services provided in a general hospital. Before you receive outpatient group or individual therapy visits, you must obtain a referral from your PCP.		
Skilled Nursing Facility (SNF)			
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 per benefit period. No prior hospital stay is required.		
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			
Ambulance	$350 copay per trip	$325 copay per trip	
What You Should Know	Prior authorization may be required for non-emergency transportation.		
Transportation			
Transportation	$40 copay per ride	$40 copay per ride	
What You Should Know	Non-ambulance transportation (e.g., by chair car/wheelchair van or sedan) through the plan-approved vendor from a hospital to a skilled nursing facility when ordered by the discharging hospital.		
Medicare Part B Drugs			
Medicare Part B drugs	For Part B chemotherapy drugs: You pay 20% of the cost. Other Part B drugs: You pay 20% of the cost.	For Part B chemotherapy drugs: You pay 20% of the cost. Other Part B drugs: You pay 20% of the cost.	
What You Should Know	Prior authorization may be required.		

Tufts Health Plan Medicare Preferred **HMO Value No Rx**	Tufts Health Plan Medicare Preferred **HMO Value Rx**	Tufts Health Plan Medicare Preferred **HMO Prime No Rx**	Tufts Health Plan Medicare Preferred **HMO Prime Rx**	Tufts Health Plan Medicare Preferred **HMO Prime Rx Plus**
Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental health services provided in a general hospital. Before you receive outpatient group or individual therapy visits, you must obtain a referral from your PCP.				
Skilled Nursing Facility (SNF)				
• $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 45 through 100
Our plan covers up to 100 days in a SNF per benefit period. No prior hospital stay is required.				
Physical Therapy				
$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.				
Ambulance				
$225 copay per day		$125 copay per day		$90 copay per day
Prior authorization may be required for non-emergency transportation.				
Transportation				
$40 copay per ride		$40 copay per ride		
Non-ambulance transportation (e.g., by chair car/wheelchair van or sedan) through the plan-approved vendor from a hospital to a skilled nursing facility when ordered by the discharging hospital.				
Medicare Part B Drugs				
For Part B chemotherapy drugs: You pay nothing. Other Part B drugs: You pay nothing.		For Part B chemotherapy drugs: You pay nothing. Other Part B drugs: You pay nothing.		
Prior authorization may be required.				

Prescription Drug Benefits: Deductible (for Part D prescription drugs)	Tufts Health Plan Medicare Preferred **HMO Saver Rx**	Tufts Health Plan Medicare Preferred **HMO Basic No Rx**	Tufts Health Plan Medicare Preferred **HMO Basic Rx**	Tufts Health Plan Medicare Preferred **HMO Value No Rx**	Tufts Health Plan Medicare Preferred **HMO Value Rx**	Tufts Health Plan Medicare Preferred **HMO Prime No Rx**	Tufts Health Plan Medicare Preferred **HMO Prime Rx**	Tufts Health Plan Medicare Preferred **HMO Prime Rx Plus**
	$250 per year for your Tier 3, Tier 4, and Tier 5 drugs	This plan does not cover Part D prescription drugs	$225 per year for your Tier 3, Tier 4, and Tier 5 drugs	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	

Prescription Drug Benefits: Initial Coverage	Tufts Health Plan Medicare Preferred **HMO Saver Rx**	Tufts Health Plan Medicare Preferred **HMO Basic No Rx**	Tufts Health Plan Medicare Preferred **HMO Basic Rx**	Tufts Health Plan Medicare Preferred **HMO Value No Rx**	Tufts Health Plan Medicare Preferred **HMO Value Rx**	Tufts Health Plan Medicare Preferred **HMO Prime No Rx**	Tufts Health Plan Medicare Preferred **HMO Prime Rx**	Tufts Health Plan Medicare Preferred **HMO Prime Rx Plus**
	• After you pay your yearly deductible of $250 for Tier 3, Tier 4, and Tier 5 drugs, you pay the following until your total yearly drug costs reach $4,130. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. • You may get your drugs at network retail pharmacies and mail order pharmacies.	This plan does not cover Part D prescription drugs	• After you pay your yearly deductible of $225 for Tier 3, Tier 4, and Tier 5 drugs, you pay the following until your total yearly drug costs reach $4,130. 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 following until your total yearly drug costs reach $4,130. 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 $4,130. 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 Health Plan Medicare Preferred **HMO Saver Rx**			Tufts Health Plan Medicare Preferred **HMO Basic Rx**		
Retail Cost Sharing—Preferred Pharmacy						
Tier	One-month supply	Two-month supply	Three-month supply	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	$0	$0	$0	$0	$0	$0
Tier 2 (Generic)	$4	$8	$12	$4	$8	$12
Tier 3 (Preferred Brand)	$47	$94	$141	$47	$94	$141
Tier 4 (Non-Preferred Drug)	$100	$200	$300	$100	$200	$300
Tier 5 (Specialty Tier)	28% of the cost	N/A	N/A	29% of the cost	N/A	N/A
Tier 6 (Vaccines)	$0	N/A	N/A	$0	N/A	N/A

Tufts Health Plan Medicare Preferred **HMO Value Rx**			Tufts Health Plan Medicare Preferred **HMO Prime Rx**			Tufts Health Plan Medicare Preferred **HMO Prime Rx Plus**		
Retail Cost Sharing—Preferred Pharmacy								
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
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A	$0	N/A	N/A

Prescription Drug Benefits: Initial Coverage	Tufts Health Plan Medicare Preferred **HMO Saver Rx**			Tufts Health Plan Medicare Preferred **HMO Basic Rx**		
Retail Cost Sharing—Non-Preferred Pharmacy						
Tier	One-month supply	Two-month supply	Three-month supply	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	$14	$28	$42	$14	$28	$42
Tier 2 (Generic)	$19	$38	$57	$19	$38	$57
Tier 3 (Preferred Brand)	$47	$94	$141	$47	$94	$141
Tier 4 (Non-Preferred Drug)	$100	$200	$300	$100	$200	$300
Tier 5 (Specialty Tier)	28% of the cost	N/A	N/A	29% of the cost	N/A	N/A
Tier 6 (Vaccines)	$0	N/A	N/A	$0	N/A	N/A
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)	$0	$0	$0	$0	$0	$0
Tier 2 (Generic)	$4	$8	$8	$4	$8	$8
Tier 3 (Preferred Brand)	$47	$94	$94	$47	$94	$94
Tier 4 (Non-Preferred Drug)	$100	$200	$300	$100	$200	$300
Tier 5 (Specialty Tier)	28% of the cost	N/A	N/A	29% of the cost	N/A	N/A
Tier 6 (Vaccines)	N/A	N/A	N/A	N/A	N/A	N/A
	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, Tier 2, and Tier 6 drugs and you pay your share of the cost. After you have met your annual $250 Tier 3, Tier 4, and Tier 5 deductible, the plan pays its share of the cost of your Tier 3, Tier 4, and Tier 5 drugs and you pay your share.			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, Tier 2, and Tier 6 drugs and you pay your share of the cost. After you have met your annual $225 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 Health Plan Medicare Preferred **HMO Value Rx**			Tufts Health Plan Medicare Preferred **HMO Prime Rx**			Tufts Health Plan Medicare Preferred **HMO Prime Rx Plus**		
Retail Cost Sharing—Non-Preferred Pharmacy								
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	$8	$12	$4	$8	$12	$2	$4	$6
$8	$16	$24	$8	$16	$24	$4	$8	$12
$45	$90	$135	$45	$90	$135	$30	$60	$90
$100	$200	$300	$100	$200	$300	$80	$160	$240
29% of the cost	N/A	N/A	33% of the cost	N/A	N/A	33% of the cost	N/A	N/A
$0	N/A	N/A	$0	N/A	N/A	$0	N/A	N/A
Mail Order Cost Sharing								
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	$8	$8	$4	$8	$8	$2	$4	$4
$8	$16	$16	$8	$16	$16	$4	$8	$8
$45	$90	$90	$45	$90	$90	$30	$60	$60
$100	$200	$300	$100	$200	$300	$80	$160	$240
29% of the cost	N/A	N/A	33% of the cost	N/A	N/A	33% of the cost	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
If you reside in a long-term care facility, you pay the same as at a 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, 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 may pay more than you pay at an in-network pharmacy. During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost.			If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy. During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost.		

Prescription Drug Benefits: Coverage Gap	Tufts Health Plan Medicare Preferred **HMO Saver Rx**	Tufts Health Plan Medicare Preferred **HMO Basic Rx**	Tufts Health Plan Medicare Preferred **HMO Value Rx**	Tufts Health Plan Medicare Preferred **HMO Prime Rx**	Tufts Health Plan 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 $4,130. After you enter the coverage gap, you pay 25% of the plan’s cost for covered brand name drugs and 25% of the plan’s cost for covered generic drugs until your costs total $6,550, 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 $4,130. After you enter the coverage gap, you pay 25% of the plan’s cost for covered brand name drugs and 25% of the plan’s cost for covered generic drugs until your costs total $6,550, 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 $4,130. After you enter the coverage gap, you pay 25% of the plan’s cost for covered brand name drugs and 25% of the plan’s cost for covered generic drugs until your costs total $6,550, 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 $4,130. After you enter the coverage gap, you pay 25% of the plan’s cost for covered brand name drugs and 25% of the plan’s cost for covered generic drugs until your costs total $6,550, 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 $4,130. After you enter the coverage gap, your cost share for Tier 3, Tier 4, Tier 5, and Tier 6 drugs will be 25% of the plan’s cost for covered brand name drugs and 25% of the plan’s cost for covered generic drugs. The table below shows your cost share for Tier 1 and Tier 2 drugs during this stage. You stay in this stage until your costs total $6,550, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Retail Cost Sharing			
Drug covered	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)			
All	$2	$4	$6
Tier 2 (Generic)			
All	$4	$8	$12
Mail Order Cost Sharing			
Tier 1 (Preferred Generic)			
All	$2	$4	$4
Tier 2 (Generic)			
All	$4	$8	$8

Prescription Drug Benefits: Catastrophic Coverage	Tufts Health Plan Medicare Preferred **HMO Saver Rx**	Tufts Health Plan Medicare Preferred **HMO Basic Rx**	Tufts Health Plan Medicare Preferred **HMO Value Rx**	Tufts Health Plan Medicare Preferred **HMO Prime Rx**	Tufts Health Plan 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 $6,550, you pay the greater of: • 5% of the cost, or • $3.70 copay for generic (including brand drugs treated as generic) and a $9.20 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 $6,550, you pay the greater of: • 5% of the cost, or • $3.70 copay for generic (including brand drugs treated as generic) and a $9.20 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 $6,550, you pay the greater of: • 5% of the cost, or • $3.70 copay for generic (including brand drugs treated as generic) and a $9.20 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 $6,550, you pay the greater of: • 5% of the cost, or • $3.70 copay for generic (including brand drugs treated as generic) and a $9.20 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 $6,550, you pay the greater of: • 5% of the cost, or • $3.70 copay for generic (including brand drugs treated as generic) and a $9.20 copayment for all other drugs.

OPTIONAL BENEFITS (You must pay an extra premium each month for these benefits)	Tufts Health Plan Medicare Preferred **HMO Saver Rx**	Tufts Health Plan Medicare Preferred **HMO Basic No Rx**	Tufts Health Plan Medicare Preferred **HMO Basic Rx**
Tufts Health Plan Medicare Preferred Dental Option			
Benefits include	• Preventive dental • Comprehensive dental	• Preventive dental • Comprehensive dental	
Monthly premium	Additional $17 per month.	Additional $17 per month.	
What You Should Know	You must keep paying your Medicare Part B premium.	You must keep paying your Medicare Part B premium and your monthly plan premium.	
Deductible	This plan does not have a deductible.	This plan does not have a deductible.	
The Tufts Health Plan Medicare Preferred Dental Option offers the following benefits:	• Preventive services such as routine cleanings and oral exams covered at 100%. You pay $0. • Restorative services such as fillings and simple extractions covered at 80%. You pay 20%. • Major services such as dentures, bridges, and crowns covered at 50%. You pay 50%.	• Preventive services such as routine cleanings and oral exams covered at 100%. You pay $0. • Restorative services such as fillings and simple extractions covered at 80%. You pay 20%. • Major services such as dentures, bridges, and crowns covered at 50%. You pay 50%.	
What You Should Know	Coverage is limited to providers within the Dominion PPO network. $1,000 calendar year maximum. No waiting period.		

OPTIONAL BENEFITS (You must pay an extra premium each month for these benefits)	Tufts Health Plan Medicare Preferred **HMO Value No Rx**	Tufts Health Plan Medicare Preferred **HMO Value Rx**	Tufts Health Plan Medicare Preferred **HMO Prime No Rx**	Tufts Health Plan Medicare Preferred **HMO Prime Rx**	Tufts Health Plan Medicare Preferred **HMO Prime Rx Plus**
Tufts Health Plan Medicare Preferred Dental Option					
Benefits include	• Preventive dental • Comprehensive dental		• Preventive dental • Comprehensive dental		
Monthly premium	Additional $30 per month.		Additional $30 per month.		
What You Should Know	You must keep paying your Medicare Part B premium and your monthly plan premium.				
Deductible	This plan does not have a deductible.		This plan does not have a deductible.		
The Tufts Health Plan Medicare Preferred Dental Option offers the following benefits:	• Preventive services such as routine cleanings and oral exams covered at 100%. You pay $0. • Restorative services such as fillings and simple extractions covered at 80%. You pay 20%. • Major services such as dentures, bridges, and crowns covered at 50%. You pay 50%.		• Preventive services such as routine cleanings and oral exams covered at 100%. You pay $0. • Restorative services such as fillings and simple extractions covered at 80%. You pay 20%. • Major services such as dentures, bridges, and crowns covered at 50%. You pay 50%.		
What You Should Know	Coverage is limited to providers within the Dominion PPO network. $1,000 calendar year maximum. No waiting period.				

Additional Benefits	Tufts Health Plan Medicare Preferred **HMO Saver Rx**	Tufts Health Plan Medicare Preferred **HMO Basic No Rx**	Tufts Health Plan Medicare Preferred **HMO Basic Rx**	Tufts Health Plan Medicare Preferred **HMO Value No Rx**	Tufts Health Plan Medicare Preferred **HMO Value Rx**	Tufts Health Plan Medicare Preferred **HMO Prime No Rx**	Tufts Health Plan Medicare Preferred **HMO Prime Rx**	Tufts Health Plan Medicare Preferred **HMO Prime Rx Plus**
Acupuncture								
Acupuncture services	$10 copay per visit	$10 copay per visit		$10 copay per visit		$10 copay per visit		
What You Should Know	Medicare covers up to 12 visits in 90 days for members with chronic low back pain. 8 additional visits covered for those demonstrating an improvement. No more than 20 visits administered annually. Before you receive services from a specialist, you must obtain a referral from your PCP. Additional acupuncture services are eligible for reimbursement under the annual Wellness Allowance benefit. 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. Before you receive services from a specialist, you must obtain a referral from your PCP. Additional acupuncture services are eligible for reimbursement under the annual Wellness Allowance benefit. See additional details under "Wellness Programs."				
Chiropractic Care								
Manual manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position)	$15 copay per visit	$15 copay per visit		$15 copay per visit		$15 copay per visit		
Initial evaluation (once per year)	$15 copay per visit	$15 copay per visit		$15 copay per visit		$15 copay per visit		
What You Should Know	Before you receive services from a specialist, you must obtain a referral from your PCP.			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		$25 copay per visit		$15 copay per visit		
What You Should Know	Before you receive services from a specialist, you must obtain a referral from your PCP.			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		You pay nothing		You pay nothing		
Home infusion therapy	You pay nothing	You pay nothing		You pay nothing		You pay nothing		
What You Should Know	Prior authorization may be required for home infusion therapy.			Prior authorization may be required for home infusion therapy.				
Hospice								
	Benefit provided by Medicare	Benefit provided by Medicare		Benefit provided by Medicare		Benefit provided by Medicare		
What You Should Know	You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.			You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.				
Medical Equipment/Supplies								
Durable medical equipment (e.g., wheelchairs, oxygen)	20% of the cost	20% of the cost		10% of the cost		10% of the cost		
Prosthetic devices (e.g., braces, artificial limbs, etc.)	20% of the cost	20% of the cost		10% of the cost		10% of the cost		

Additional Benefits	Tufts Health Plan Medicare Preferred **HMO Saver Rx**	Tufts Health Plan Medicare Preferred **HMO Basic No Rx**	Tufts Health Plan Medicare Preferred **HMO Basic Rx**
What You Should Know	Additional 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 pairs every 6 months • Mastectomy sleeves for members with upper limb lymphedema: up to 2 pairs every 6 months Prior authorization may be required.		
Wig allowance (for hair loss due to cancer treatment)	$500 per year	$500 per year	
Diabetes services and supplies	You pay nothing	You pay nothing	
What You Should Know	Includes diabetes monitoring supplies, diabetes self-management training, and therapeutic shoes or inserts. Copay may apply if you receive other medical services during the same office visit. Referral required for diabetes self-management training only. Coverage for blood glucose monitors, 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.		
Outpatient Substance Abuse			
Group or individual therapy visit	$25 copay per visit	$25 copay per visit	
What You Should Know	Before you receive services from a specialist, you must obtain a referral from your PCP.		
Renal Dialysis			
	20% of the cost	20% of the cost	
Telehealth/Telemedicine Services			
	Medicare-covered services plus additional telehealth services including PCP services, Specialist services, and more. Applicable office visit cost share applies for non-Opioid Telehealth Services. Opioid Services cost share applies to Opioid Telehealth Services rendered as part of Opioid Treatment Program Services episode. Referral is required for some additional telehealth services.		
Wellness Programs			
Over-the-counter (OTC) for Medicare items	$50 per calendar quarter	N/A	
What You Should Know	No rollover of unused calendar quarter balance. Items available only from the OTC catalog supplied by the plan approved vendor.	N/A	

Tufts Health Plan Medicare Preferred **HMO Value No Rx**	Tufts Health Plan Medicare Preferred **HMO Value Rx**	Tufts Health Plan Medicare Preferred **HMO Prime No Rx**	Tufts Health Plan Medicare Preferred **HMO Prime Rx**	Tufts Health Plan Medicare Preferred **HMO Prime Rx Plus**
Additional 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 pairs every 6 months • Mastectomy sleeves for members with upper limb lymphedema: up to 2 pairs every 6 months Prior authorization may be required.				
$500 per year		$500 per year		
You pay nothing		You pay nothing		
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.				
Outpatient Substance Abuse				
$20 copay per visit		$10 copay per visit		
Before you receive services from a specialist, you must obtain a referral from your PCP.				
Renal Dialysis				
20% of the cost		20% of the cost		
Telehealth Services				
Medicare-covered services plus additional telehealth services including PCP services, Specialist services, and more. Applicable office visit cost share applies for non-Opioid Telehealth Services. Opioid Services cost share applies to Opioid Telehealth Services rendered as part of Opioid Treatment Program Services episode. Referral is required for some additional telehealth services.				
Wellness Programs				
N/A				
N/A				

Additional Benefits	Tufts Health Plan Medicare Preferred **HMO Saver Rx**	Tufts Health Plan Medicare Preferred **HMO Basic No Rx**	Tufts Health Plan Medicare Preferred **HMO Basic Rx**	Tufts Health Plan Medicare Preferred **HMO Value No Rx**	Tufts Health Plan Medicare Preferred **HMO Value Rx**	Tufts Health Plan Medicare Preferred **HMO Prime No Rx**	Tufts Health Plan Medicare Preferred **HMO Prime Rx**	Tufts Health Plan Medicare Preferred **HMO Prime Rx Plus**
Weight Management program	The plan provides a $150 annual Weight Management Allowance towards program fees for weight loss programs such as WeightWatchers®, Jenny Craig®, or a hospital-based weight loss program.			The plan provides a $150 annual Weight Management Allowance towards program fees for weight loss programs such as WeightWatchers®, Jenny Craig®, or a hospital-based weight loss program.				
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.		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.				
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.		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

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: 711)
Fax: 1-617-972-9048
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 (TDD: 1-800-537-7697)

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

thpmp.org | 1-800-701-9000 (TTY: 711)

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 (TTY: 711).

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

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

Gujarati: સુચના: જો તમે ગુજરાતી બોલતા હો, તો 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 1-800-701-9000 (TTY: 711).

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

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

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

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

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

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

Questions

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

TUFTS Health Plan

705 Mount Auburn Street
Watertown, MA 02472