Look Inside

- Plan benefits
- Prescription drug benefits
- Service area listing

TUFTS MEDICARE PREFERRED HMO PLANS | 2015

Summary of Benefits

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

Please Note: Not all plans listed in this Summary of Benefits are available in all of the listed counties above, refer to the premium tables found on pages 25-26 for more details.

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

Effective January 1, 2015–December 31, 2015

H2256_2015_46 Accepted

SECTION I
INTRODUCTION TO SUMMARY OF BENEFITS

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.

Sections in this booklet

- Things to Know About Tufts Medicare Preferred HMO
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

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

This document may be available in a non-English language. For additional information, call us at 1-800-701-9000.

Esta información está disponible gratis en otros idiomas. Para obtener información adicional llame nuestro Servicios para Miembros al 1-800-701-9000.

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 1-800-978-2222.
- 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.

Our service area includes the following counties in Massachusetts: Barnstable, Bristol, Essex, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, and Suffolk.

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).

Or, call us and we will send you a copy of the provider directory.

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 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 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.

If you have any questions about this plan's benefits or costs, please contact Tufts Health Plan or Tufts Medicare Preferred for details.

SECTION II – SUMMARY OF BENEFITS

Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services

	Tufts Medicare Preferred HMO Basic No Rx	Tufts Medicare Preferred HMO Basic Rx
How much is the monthly premium?	Please refer to the Premium/Cost-Sharing Table to find out the premium/cost-sharing in your area.	Please refer to the Premium/Cost-Sharing Table to find out the premium/cost-sharing in your area.
How much is the deductible?	This plan does not have a deductible.	$150 per year for Part D prescription drugs.
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • $3,400 for services you receive from in-network providers. 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.	
Is there a limit on how much the plan will pay?	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.	

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

Tufts Medicare Preferred HMO Value No Rx	Tufts Medicare Preferred HMO Value Rx	Tufts Medicare Preferred HMO Prime No Rx	Tufts Medicare Preferred HMO Prime Rx	Tufts Medicare Preferred HMO Prime Rx Plus

Tufts Medicare Preferred HMO Value No Rx / Value Rx	Tufts Medicare Preferred HMO Prime No Rx / Prime Rx / Prime Rx Plus
Please refer to the Premium/Cost-Sharing Table to find out the premium/cost-sharing in your area.	Please refer to the Premium/Cost-Sharing Table to find out the premium/cost-sharing in your area.
This plan does not have a deductible.	This plan does not have a deductible.
Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • $3,400 for services you receive from in-network providers. 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.	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • $3,400 for services you receive from in-network providers. 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.
Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.

OUTPATIENT CARE AND SERVICES

	Tufts Medicare Preferred HMO Basic No Rx	Tufts Medicare Preferred HMO Basic Rx
Acupuncture and Other Alternative Therapies	Not Covered	
Ambulance	$200 copay Copay applies per day.	
Chiropractic Care[2]	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): $15 copay Copay applies per visit.	
Dental Services	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): $30 copay Copay applies per visit.	
Diabetes Supplies and Services[2]	Diabetes monitoring supplies: You pay nothing Diabetes self-management training: You pay nothing Therapeutic shoes or inserts: You pay nothing Copay may apply if you receive other medical services during the same office visit. Referral required for diabetes self-management training only.	
Diagnostic Tests, Lab and Radiology Services, and X-Rays	Diagnostic radiology services (such as MRIs, CT scans): $150 copay Diagnostic tests and procedures: You pay nothing Lab services: You pay nothing Outpatient X-rays: You pay nothing Therapeutic radiology services (such as radiation treatment for cancer): You pay nothing Copay applies per day.	

NOTE: Services with a [1] may require prior authorization | Services with a [2] may require a referral from your doctor

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
Not Covered		Not Covered		
$100 copay Copay applies per day.		$50 copay Copay applies per day.		
Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): $15 copay Copay applies per visit.		Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): $15 copay Copay applies per visit.		
Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): $20 copay Copay applies per visit.		Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): $15 copay Copay applies per visit.		
Diabetes monitoring supplies: You pay nothing Diabetes self-management training: You pay nothing Therapeutic shoes or inserts: You pay nothing Copay may apply if you receive other medical services during the same office visit. Referral required for diabetes self-management training only.		Diabetes monitoring supplies: You pay nothing Diabetes self-management training: You pay nothing Therapeutic shoes or inserts: You pay nothing Copay may apply if you receive other medical services during the same office visit. Referral required for diabetes self-management training only.		
Diagnostic radiology services (such as MRIs, CT scans): $75 copay Diagnostic tests and procedures: You pay nothing Lab services: You pay nothing Outpatient X-rays: You pay nothing Therapeutic radiology services (such as radiation treatment for cancer): You pay nothing Copay applies per day.		Diagnostic radiology services (such as MRIs, CT scans): 20% of the cost Diagnostic tests and procedures: You pay nothing Lab services: You pay nothing Outpatient X-rays: You pay nothing Therapeutic radiology services (such as radiation treatment for cancer): You pay nothing Copay applies per day. You will not pay more than $75 per day for diagnostic radiology services.		

OUTPATIENT CARE AND SERVICES

	Tufts Medicare Preferred HMO Basic No Rx	Tufts Medicare Preferred HMO Basic Rx
Doctor's Office Visits[2]	Primary care physician visit: $0-15 copay, depending on the service Specialist visit: $30 copay Copay applies per visit. Before you receive services from a specialist, you must obtain a referral from your PCP.	
Durable Medical Equipment *(wheelchairs, oxygen, etc.)*[1]	20% of the cost 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 per lifetime • Standard bathroom grab bars: 2 per member per lifetime • Standard tub seat: 1 per member per lifetime	
Emergency Care	$65 copay Copay applies per visit. Your plan includes worldwide coverage for emergency care.	
Foot Care *(podiatry services)*[2]	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: $30 copay Copay applies per visit.	
Hearing Services[2]	Exam to diagnose and treat hearing and balance issues: $30 copay Routine hearing exam (for up to 1 every year): $30 copay Copay applies per visit. No referral required for routine hearing exams.	
Home Health Care	You pay nothing	

NOTE: Services with a [1] may require prior authorization | Services with a [2] may require a referral from your doctor

<table>
<tr><th>Tufts Medicare Preferred HMO Value No Rx</th><th>Tufts Medicare Preferred HMO Value Rx</th><th>Tufts Medicare Preferred HMO Prime No Rx</th><th>Tufts Medicare Preferred HMO Prime Rx</th><th>Tufts Medicare Preferred HMO Prime Rx Plus</th></tr>
<tr><td colspan="2">Primary care physician visit: $0-15 copay, depending on the service
Specialist visit: $20 copay
Copay applies per visit. Before you receive services from a specialist, you must obtain a referral from your PCP.</td><td colspan="3">Primary care physician visit: $0-10 copay, depending on the service
Specialist visit: $15 copay
Copay applies per visit. Before you receive services from a specialist, you must obtain a referral from your PCP.</td></tr>
<tr><td colspan="2">10% of the cost
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 per lifetime
• Standard bathroom grab bars: 2 per member per lifetime
• Standard tub seat: 1 per member per lifetime</td><td colspan="3">10% of the cost
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 per lifetime
• Standard bathroom grab bars: 2 per member per lifetime
• Standard tub seat: 1 per member per lifetime</td></tr>
<tr><td colspan="2">$65 copay
Copay applies per visit.
Your plan includes worldwide coverage for emergency care.</td><td colspan="3">$65 copay
Copay applies per visit.
Your plan includes worldwide coverage for emergency care.</td></tr>
<tr><td colspan="2">Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: $20 copay
Copay applies per visit.</td><td colspan="3">Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: $15 copay
Copay applies per visit.</td></tr>
<tr><td colspan="2">Exam to diagnose and treat hearing and balance issues: $20 copay
Routine hearing exam (for up to 1 every year): $20 copay
Copay applies per visit.
No referral required for routine hearing exams.</td><td colspan="3">Exam to diagnose and treat hearing and balance issues: $15 copay
Routine hearing exam (for up to 1 every year): $15 copay
Copay applies per visit.
No referral required for routine hearing exams.</td></tr>
<tr><td colspan="2">You pay nothing</td><td colspan="3">You pay nothing</td></tr>
</table>

OUTPATIENT CARE AND SERVICES

	Tufts Medicare Preferred HMO Basic No Rx	Tufts Medicare Preferred HMO Basic Rx
Mental Health Care[2]	Inpatient 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. • $250 copay per day for days 1 through 5 • You pay nothing per day for days 6 through 90 Outpatient group therapy visit: $30 copay Outpatient individual therapy visit: $30 copay Outpatient copay applies per visit.	Inpatient 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. • $225 copay per day for days 1 through 5 • You pay nothing per day for days 6 through 90 Outpatient group therapy visit: $30 copay Outpatient individual therapy visit: $30 copay Outpatient copay applies per visit.
Outpatient Rehabilitation[2]	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): You pay nothing Occupational therapy visit: $30 copay Physical therapy and speech and language therapy visit: $0-30 copay, depending on the service Copay applies per visit. Speech therapy visit: $30 copay. Physical therapy visit: • $0 copay for visits 1-6 • $30 copay for visits 7 and beyond	

NOTE: Services with a [1] may require prior authorization | Services with a [2] may require a referral from your doctor

<table>
<tr><th>Tufts Medicare Preferred HMO Value No Rx</th><th>Tufts Medicare Preferred HMO Value Rx</th><th>Tufts Medicare Preferred HMO Prime No Rx</th><th>Tufts Medicare Preferred HMO Prime Rx</th><th>Tufts Medicare Preferred HMO Prime Rx Plus</th></tr>
<tr><td colspan="2">Inpatient 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.
• $170 copay per day for days 1 through 5
• You pay nothing per day for days 6 through 90
Outpatient group therapy visit: $20 copay
Outpatient individual therapy visit: $20 copay
Outpatient copay applies per visit.</td><td colspan="3">Inpatient 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.
• $200 copay per stay
Outpatient group therapy visit: $15 copay
Outpatient individual therapy visit: $15 copay
Outpatient copay applies per visit. You will not pay more than $400 for inpatient hospital covered services in a calendar year.</td></tr>
<tr><td colspan="2">Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks):
You pay nothing
Occupational therapy visit: $20 copay
Physical therapy and speech and language therapy visit:
$0-20 copay, depending on the service
Copay applies per visit.
Speech therapy visit: $20 copay.
Physical therapy visit:
• $0 copay for visits 1-6
• $20 copay for visits 7 and beyond</td><td colspan="3">Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks):
You pay nothing
Occupational therapy visit: $15 copay
Physical therapy and speech and language therapy visit:
$0-15 copay, depending on the service
Copay applies per visit.
Speech therapy visit: $15 copay.
Physical therapy visit:
• $0 copay for visits 1-6
• $15 copay for visits 7 and beyond</td></tr>
</table>

OUTPATIENT CARE AND SERVICES

	Tufts Medicare Preferred HMO Basic No Rx	Tufts Medicare Preferred HMO Basic Rx
Outpatient Substance Abuse[2]	Group therapy visit: $30 copay Individual therapy visit: $30 copay Copay applies per visit.	
Outpatient Surgery[2]	Ambulatory surgical center: $200 copay Outpatient hospital: $200 copay Copay applies per visit. $0 for a 15 minute consultation for Physical or Occupational therapy prior to discharge.	
Over-the-Counter Items	Not covered	
Prosthetic Devices *(braces, artificial limbs, etc.)*[1]	Prosthetic devices: 20% of the cost Related medical supplies: You pay nothing The following additional items are covered by the plan: • Gradient compression stockings or surgical stockings; or 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 $350 per calendar year	
Renal Dialysis	You pay nothing	
Transportation	Not covered	
Urgent Care	$15-65 copay, depending on the service Copay applies per visit. Urgently needed care may be furnished by in-network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. Your plan includes worldwide coverage for urgently needed care.	

NOTE: Services with a [1] may require prior authorization | Services with a [2] may require a referral from your doctor

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
Group therapy visit: $20 copay Individual therapy visit: $20 copay Copay applies per visit.		Group therapy visit: $15 copay Individual therapy visit: $15 copay Copay applies per visit.		
Ambulatory surgical center: $150 copay Outpatient hospital: $150 copay Copay applies per visit. $0 for a 15 minute consultation for Physical or Occupational therapy prior to discharge.		Ambulatory surgical center: $100 copay Outpatient hospital: $100 copay Copay applies per visit. $0 for a 15 minute consultation for Physical or Occupational therapy prior to discharge.		
Not covered		Not covered		
Prosthetic devices: 10% of the cost Related medical supplies: You pay nothing The following additional items are covered by the plan: • Gradient compression stockings or surgical stockings; or 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 $350 per calendar year		Prosthetic devices: 10% of the cost Related medical supplies: You pay nothing The following additional items are covered by the plan: • Gradient compression stockings or surgical stockings; or 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 $350 per calendar year		
You pay nothing		You pay nothing		
Not covered		Not covered		
$15-65 copay, depending on the service Copay applies per visit. Urgently needed care may be furnished by in-network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. Your plan includes worldwide coverage for urgently needed care.		$10-65 copay, depending on the service Copay applies per visit. Urgently needed care may be furnished by in-network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. Your plan includes worldwide coverage for urgently needed care.		

OUTPATIENT CARE AND SERVICES

	Tufts Medicare Preferred HMO Basic No Rx	Tufts Medicare Preferred HMO Basic Rx
Vision Services[2]	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0 - 30 copay, depending on the service Routine eye exam (for up to 1 every year): $30 copay Contact lenses: You pay nothing Eyeglasses (frames and lenses): You pay nothing Eyeglasses or contact lenses after cataract surgery: You pay nothing Our plan pays up to $150 every year for contact lenses and eyeglasses (frames and lenses). Copay applies per visit. You must use an EyeMed Vision Care provider in order to receive the covered Routine Eye Exam benefit. You must purchase your glasses or contacts from an EyeMed provider in order to receive the $150 per year allowance. Otherwise, the benefit will be limited to $90 per year.	
Preventive Care	You pay nothing Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colonoscopy • Colorectal cancer screenings • Depression screening • Diabetes screenings • Fecal occult blood test • Flexible sigmoidoscopy	

NOTE: Services with a [1] may require prior authorization | Services with a [2] may require a referral from your doctor

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
Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0 - 20 copay, depending on the service Routine eye exam (for up to 1 every year): $20 copay Contact lenses: You pay nothing Eyeglasses (frames and lenses): You pay nothing Eyeglasses or contact lenses after cataract surgery: You pay nothing Our plan pays up to $150 every year for contact lenses and eyeglasses (frames and lenses). Copay applies per visit. You must use an EyeMed Vision Care provider in order to receive the covered Routine Eye Exam benefit. You must purchase your glasses or contacts from an EyeMed provider in order to receive the $150 per year allowance. Otherwise, the benefit will be limited to $90 per year.		Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0 - 15 copay, depending on the service Routine eye exam (for up to 1 every year): $15 copay Contact lenses: You pay nothing Eyeglasses (frames and lenses): You pay nothing Eyeglasses or contact lenses after cataract surgery: You pay nothing Our plan pays up to $150 every year for contact lenses and eyeglasses (frames and lenses). Copay applies per visit. You must use an EyeMed Vision Care provider in order to receive the covered Routine Eye Exam benefit. You must purchase your glasses or contacts from an EyeMed provider in order to receive the $150 per year allowance. Otherwise, the benefit will be limited to $90 per year.		
You pay nothing Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colonoscopy • Colorectal cancer screenings • Depression screening • Diabetes screenings • Fecal occult blood test • Flexible sigmoidoscopy		You pay nothing Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colonoscopy • Colorectal cancer screenings • Depression screening • Diabetes screenings • Fecal occult blood test • Flexible sigmoidoscopy		

OUTPATIENT CARE AND SERVICES

	Tufts Medicare Preferred HMO Basic No Rx	Tufts Medicare Preferred HMO Basic Rx
Preventive Care continued	• HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered.	
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.	

INPATIENT CARE

	Tufts Medicare Preferred HMO Basic No Rx	Tufts Medicare Preferred HMO Basic Rx
Inpatient Hospital Care	Our plan covers an unlimited number of days for an inpatient hospital stay. • $250 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	Our plan covers an unlimited number of days for an inpatient hospital stay. • $225 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
Inpatient Mental Health Care	For inpatient mental health care, see the "Mental Health Care" section of this booklet.	
Skilled Nursing Facility (SNF)	Our plan covers up to 100 days in a SNF. • $40 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	

NOTE: Services with a [1] may require prior authorization | Services with a [2] may require a referral from your doctor

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
• HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • “Welcome to Medicare” preventive visit (one-time) • Yearly “Wellness” visit Any additional preventive services approved by Medicare during the contract year will be covered.		• HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • “Welcome to Medicare” preventive visit (one-time) • Yearly “Wellness” visit Any additional preventive services approved by Medicare during the contract year will be covered.		
You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.		You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.		
Our plan covers an unlimited number of days for an inpatient hospital stay. • $170 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		Our plan covers an unlimited number of days for an inpatient hospital stay. • $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.		
For inpatient mental health care, see the “Mental Health Care” section of this booklet.		For inpatient mental health care, see the “Mental Health Care” section of this booklet.		
Our plan covers up to 100 days in a SNF. • $30 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		Our plan covers up to 100 days in a SNF. • $20 copay per day for days 1 through 20 • $0 copay per day for days 21 through 100		

PRESCRIPTION DRUG BENEFITS

	Tufts Medicare Preferred HMO Basic No Rx	Tufts Medicare Preferred HMO Basic Rx			Tufts Medicare Preferred HMO Value No Rx
How much do I pay?					
	For Part B drugs such as chemotherapy drugs[1]: You pay nothing Other Part B drugs[1]: You pay nothing Our plan does not cover Part D prescription drugs	For Part B drugs such as chemotherapy drugs[1]: You pay nothing Other Part B drugs[1]: You pay nothing			For Part B drugs such as chemotherapy drugs[1]: You pay nothing Other Part B drugs[1]: You pay nothing Our plan does not cover Part D prescription drugs.
Initial Coverage					
		After you pay your yearly deductible, you pay the following until your total yearly drug costs reach $2,960. 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.			
Standard Retail Cost-Sharing					
Tier		**One-month supply**	**Two-month supply**	**Three-month supply**	
Tier 1 (Preferred Generic)		$4 copay	$8 copay	$12 copay	
Tier 2 (Non-Preferred Generic)		$8 copay	$16 copay	$24 copay	
Tier 3 (Preferred Brand)		$45 copay	$90 copay	$135 copay	
Tier 4 (Non-Preferred Brand)		$95 copay	$190 copay	$285 copay	
Tier 5 (Specialty Tier)		29% of the cost			

NOTE: Services with a [1] may require prior authorization | Services with a [2] may require a referral from your doctor

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[1]: You pay nothing Other Part B drugs[1]: You pay nothing	For Part B drugs such as chemotherapy drugs[1]: You pay nothing Other Part B drugs[1]: You pay nothing Our plan does not cover Part D prescription drug	For Part B drugs such as chemotherapy drugs[1]: You pay nothing Other Part B drugs[1]: You pay nothing	For Part B drugs such as chemotherapy drugs[1]: You pay nothing Other Part B drugs[1]: You pay nothing
After you pay your yearly deductible, you pay the following until your total yearly drug costs reach $2,960. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.		After you pay your yearly deductible, you pay the following until your total yearly drug costs reach $2,960. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.	After you pay your yearly deductible, you pay the following until your total yearly drug costs reach $2,960. 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.

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	$5 copay	$10 copay	$15 copay
$45 copay	$90 copay	$135 copay		$45 copay	$90 copay	$135 copay	$30 copay	$60 copay	$90 copay
$95 copay	$190 copay	$285 copay		$95 copay	$190 copay	$285 copay	$80 copay	$160 copay	$240 copay
33% of the cost				33% of the cost			33% of the cost		

	Tufts Medicare Preferred HMO Basic No Rx	Tufts Medicare Preferred HMO Basic Rx			Tufts Medicare Preferred HMO Value No Rx
Initial Coverage continued					
Standard Mail Order Cost-Sharing					
Tier		**One-month supply**	**Two-month supply**	**Three-month supply**	
Tier 1 (Preferred Generic)		$3 copay	$7 copay	$10 copay	
Tier 2 (Non-Preferred Generic)		$7 copay	$14 copay	$21 copay	
Tier 3 (Preferred Brand)		$45 copay	$90 copay	$135 copay	
Tier 4 (Non-Preferred Brand)		$95 copay	$190 copay	$285 copay	
Tier 5 (Specialty Tier)		29% 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 Tier 1 and Tier 2 drugs and you pay your share of the cost. After you have met your annual $150 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 No 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**
$3 copay	$7 copay	$10 copay		$3 copay	$7 copay	$10 copay	$2 copay	$3 copay	$5 copay
$7 copay	$14 copay	$21 copay		$7 copay	$14 copay	$21 copay	$4 copay	$8 copay	$12 copay
$45 copay	$90 copay	$135 copay		$45 copay	$90 copay	$135 copay	$30 copay	$60 copay	$90 copay
$95 copay	$190 copay	$285 copay		$95 copay	$190 copay	$285 copay	$80 copay	$160 copay	$240 copay
33% of the cost				33% of the cost			33% 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.				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 Basic No Rx	Tufts Medicare Preferred HMO Basic Rx	Tufts Medicare Preferred HMO Value No Rx
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 $2,960. After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 65% of the plan's cost for covered generic drugs until your costs total $4,700, 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 No 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 $2,960. After you enter the coverage gap, you pay 45% of the plan’s cost for covered brand name drugs and 65% of the plan’s cost for covered generic drugs until your costs total $4,700, 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 $2,960. After you enter the coverage gap, you pay 45% of the plan’s cost for covered brand name drugs and 65% of the plan’s cost for covered generic drugs until your costs total $4,700, 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 $2,960. After you enter the coverage gap, you pay 45% of the plan’s cost for covered brand name drugs and 65% of the plan’s cost for covered generic drugs until your costs total $4,700, 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 Basic No Rx	Tufts Medicare Preferred HMO Basic Rx	Tufts Medicare Preferred HMO Value No Rx
Catastrophic Coverage			
		After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,700, you pay the greater of: • 5% of the cost, or • $2.65 copay for generic (including brand drugs treated as generic) and a $6.60 copayment for all other drugs.	

<table>
<tr><th>Tufts Medicare Preferred
HMO Value Rx</th><th>Tufts Medicare Preferred
HMO Prime No Rx</th><th>Tufts Medicare Preferred
HMO Prime Rx</th><th colspan="3">Tufts Medicare Preferred
HMO Prime Rx Plus</th></tr>
<tr><td colspan="6"></td></tr>
<tr><td rowspan="12"></td><td rowspan="12"></td><td rowspan="12"></td><td colspan="3">Standard Retail Cost-Sharing Tier Drugs Covered</td></tr>
<tr><td colspan="3">Tier 1 (Preferred Generic) All</td></tr>
<tr><td>One-month supply</td><td>Two-month supply</td><td>Three-month supply</td></tr>
<tr><td>$2 copay</td><td>$4 copay</td><td>$6 copay</td></tr>
<tr><td colspan="3">Tier 2 (Non-Preferred Generic) All</td></tr>
<tr><td>$5 copay</td><td>$10 copay</td><td>$15 copay</td></tr>
<tr><td colspan="3">Standard Mail Order Cost-Sharing Tier Drugs Covered</td></tr>
<tr><td colspan="3">Tier 1 (Preferred Generic) All</td></tr>
<tr><td>One-month supply</td><td>Two-month supply</td><td>Three-month supply</td></tr>
<tr><td>$2 copay</td><td>$3 copay</td><td>$5 copay</td></tr>
<tr><td colspan="3">Tier 2 (Non-Preferred Generic) All</td></tr>
<tr><td>$4 copay</td><td>$8 copay</td><td>$12 copay</td></tr>
<tr><td colspan="6"></td></tr>
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reach $4,700, you pay the greater of:
• 5% of the cost, or
• $2.65 copay for generic (including brand drugs treated as generic) and a $6.60 copayment for all other drugs.</td><td></td><td>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order)
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• 5% of the cost, or
• $2.65 copay for generic (including brand drugs treated as generic) and a $6.60 copayment for all other drugs.</td><td colspan="3">After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order)
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• 5% of the cost, or
• $2.65 copay for generic (including brand drugs treated as generic) and a $6.60 copayment for all other drugs.</td></tr>
</table>

Tufts Medicare Preferred HMO Premium/Cost Sharing Table

Below is a Premium Table by county for the Tufts Medicare Preferred HMO plans. You must live in one of these areas to join this plan. To use this table, find your county of residence. Then you can compare the premium costs for each of the seven Tufts Medicare Preferred HMO plans that are listed in Section 2 (pages 3-24)* You must continue to pay your Medicare Part B premium if not otherwise paid for under Medicaid or by a third party.

Plan Premiums by County	Plan premiums*
Bristol, Barnstable, Middlesex, Norfolk and Plymouth	
Tufts Medicare Preferred HMO Basic No Rx	N/A
Tufts Medicare Preferred HMO Basic Rx	$35.90
Tufts Medicare Preferred HMO Value No Rx	$96.00
Tufts Medicare Preferred HMO Value Rx	$120.30
Tufts Medicare Preferred HMO Prime No Rx	$130.00
Tufts Medicare Preferred HMO Prime Rx	$154.40
Tufts Medicare Preferred HMO Prime Rx Plus	$188.20

Plan Premiums by County	Plan premiums*
Hampden and Hampshire	
Tufts Medicare Preferred HMO Basic No Rx	N/A
Tufts Medicare Preferred HMO Basic Rx	$0
Tufts Medicare Preferred HMO Value No Rx	$22.00
Tufts Medicare Preferred HMO Value Rx	$46.30
Tufts Medicare Preferred HMO Prime No Rx	$52.00
Tufts Medicare Preferred HMO Prime Rx	$76.40
Tufts Medicare Preferred HMO Prime Rx Plus	$110.20
Suffolk and Essex	
Tufts Medicare Preferred HMO Basic No Rx	$34.00
Tufts Medicare Preferred HMO Basic Rx	$55.90
Tufts Medicare Preferred HMO Value No Rx	$117.00
Tufts Medicare Preferred HMO Value Rx	$141.30
Tufts Medicare Preferred HMO Prime No Rx	$154.00
Tufts Medicare Preferred HMO Prime Rx	$178.40
Tufts Medicare Preferred HMO Prime Rx Plus	$212.20

* You must continue to pay your Medicare Part B premium if not otherwise paid for under Medicaid or by a third party.

SECTION III
Additional Information About Tufts Medicare Preferred HMO Plans

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.

Wellness & Weight Management Programs

The plan provides a $150 annual wellness allowance toward health club memberships, nutritional counseling, or fitness classes like Pilates, Tai Chi, or aerobics, and wellness programs, including memory fitness activities.

The plan also provides a $150 annual weight management allowance towards program fees for weight loss programs such as WeightWatchers, Jenny Craig, Nutrisystem, or a hospital-based weight loss program.

Limitations and Exclusions

The benefits listed in this document may be subject to limitations and exclusions. When you become a member of a Tufts Medicare Preferred HMO plan, you will receive an Evidence of Coverage book that explains all the limitations and exclusions.

Multi-language Interpreter Services

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

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

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

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

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

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

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

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

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화1-800-701-9000번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

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

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على1-800-701-9000. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

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

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

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

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

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

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

QUESTIONS?

Call 1-800-978-2222 // TTY 1-888-899-8977

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

This information is available for free in other languages. Please call our Customer Relations number at 1-800-701-9000 or, for TTY users, 1-800-208-9562, Monday - Friday 8:00 a.m. - 8:00 p.m. (from Oct. 1 - Feb. 14 representatives are available 7 days a week, 8:00 a.m. - 8:00 p.m.). After hours and on holidays, please leave a message and a representative will return your call on the next business day.

Esta información está disponible gratuitamente en otros idiomas. Sírvase llamar a nuestro número de Servicio al Cliente al 1-800-701-9000 o, para usuarios con problemas auditivos (TTY), al 1-800-208-9562, de lunes a viernes, desde las 8:00 a.m. hasta las 8:00 p.m. (desde el 1 de octubre hasta el 14 de febrero hay representantes disponibles los 7 días de la semana, desde las 8:00 a.m. hasta las 8:00 p.m.). Después del horario de atención y en días feriados, por favor deje un mensaje y un representante le devolverá su llamada el día laborable siguiente.

TUFTS Health Plan
Medicare Preferred