TUFTS MEDICARE PREFERRED HMO PLANS | 2020

Summary of Benefits

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

Tufts Medicare Preferred HMO Saver Rx

Tufts Medicare Preferred HMO Basic No Rx

Tufts Medicare Preferred HMO Basic Rx

Tufts Medicare Preferred HMO Value No Rx

Tufts Medicare Preferred HMO Value Rx

Tufts Medicare Preferred HMO Prime No Rx

Tufts Medicare Preferred HMO Prime Rx

Tufts Medicare Preferred HMO Prime Rx Plus

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



SUMMARY OF BENEFITS January 1, 2020 – December 31, 2020

You have choices about how to get your Medicare benefits

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

Tips for comparing your Medicare choices

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

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

Things to Know About Tufts Medicare Preferred HMO

Tufts Medicare Preferred HMO phone numbers and website

- If you are a member of this plan, call toll-free 1-800-701-9000 (TTY: 711).
- If you are not a member of this plan, call toll-free 1-888-515-5880 (TTY: 711).
- Our website: www.thpmp.org

Who can join?

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

The service area for the plans described in this document includes the following counties in Massachusetts: Barnstable, Bristol, Essex, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester.

Which doctors, hospitals, and pharmacies can I use?

Tufts Medicare Preferred HMO has a network of doctors, hospitals, pharmacies, and other providers. If you use 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). Or, call us and we will send you a copy of the Provider Directory and Pharmacy Directory.

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

Referral Circles

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

What do we cover?

We cover everything that Original Medicare covers - and more.

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

Tufts Medicare Preferred HMO Saver Rx, Tufts Medicare Preferred HMO Basic Rx, Tufts Medicare Preferred HMO Value Rx, Tufts Medicare Preferred HMO Prime Rx, and Tufts Medicare Preferred HMO Prime Rx Plus cover Part D drugs. In addition, all plans cover Part B drugs such as chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, www.thpmp.org.
- Or, call us and we will send you a copy of the formulary.

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

Our plan groups each medication into one of 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, Coverage Gap, and Catastrophic Coverage.

	Tufts Medicare Preferred HMO Saver Rx	Tufts Medicare Preferred HMO Basic No Rx	Tufts Medicare Preferred HMO Basic Rx	
Monthly Plan Prem	ium			
Barnstable, Bristol, Middlesex, Norfolk & Plymouth	\$0 per month	Not offered	\$40.00 per month	
Essex & Suffolk	\$0 per month	\$28.00 per month	\$55.00 per month	
Hampden & Hampshire	\$0 per month	Not offered	\$27.00 per month	
Worcester	\$0 per month	\$20.00 per month	\$42.00 per month	
What You Should Know	In addition, you must keep payi	ng your Medicare Part	B premium.	
Deductible (for Part I	prescription drugs except for drugs listed on Tiers 1	1, 2, and 6 which are exclud	led from the deductible)	
	\$250 per year	This plan does not cover prescription drugs.	\$225 per year	
Maximum Out-of-P	ocket Responsibility (does not include presc	cription drugs)		
	\$6,700 annually	\$3,400	annually	
What You Should Know	Like all Medicare health p by having yearly limits on your out-of-p If you reach the limit on out-of-pocket cos hospital and medical services for the rest of the your monthly premiums (and cost-sharing fo	ocket costs for medical sts, we will pay the full co e year. Please note that yo	and hospital care. ost of your covered ou will still need to pa	
INPATIENT AND	OUTPATIENT CARE AND SERVICES			
Inpatient Hospital				
	 \$350 copay per day for days 1 through 5 You pay nothing per day for days 6 through 90 You pay nothing per day for days 91 and beyond 	 \$275 copay per day for days 1 throu You pay nothing per day for days 6 through 90 You pay nothing per day for days 91 and beyond 		
What You Should Know	•	ber of days for an inpatient hospital stay. tion may be required.		
Outpatient Surgery				
Ambulatory surgical center	\$350 copay per day	\$250 copa	y per day	
Outpatient hospital	\$350 copay per day	\$250 copa	y per day	
What You	Before you receive services, you m	nust obtain a referral fro	om your PCP.	

Prior authorization may be required.

Should Know

Tufts Medicare Preferred HMO Value No Rx	Tufts Medicare Preferred HMO Value Rx	Tufts Medicare Preferred HMO Prime No Rx	Tufts Medicare Preferred HMO Prime Rx	Tufts Medicare Preferred HMO Prime Rx Plus
\$103.00 per month	\$135.00 per month	\$133.00 per month	\$165.00 per month	\$199.00 per month
\$123.00 per month	\$155.00 per month	\$156.00 per month	\$188.00 per month	\$220.00 per month
Not offered	\$58.00 per month	Not offered	\$83.00 per month	\$103.00 per month
\$112.00 per month	\$150.00 per month	\$152.00 per month	\$185.00 per month	Not offered

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

This plan does not cover	\$200 per year	This plan does not cover	This plan does not	This plan does not
prescription drugs.		prescription drugs.	have a deductible.	have a deductible.
\$3,400	annually		\$3,400 annually	
\$5,400	ammamy		\$3,400 annuany	

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).

 \$200 copay per day for days 1 through 5 You pay nothing per day for days 6 through 90 You pay nothing per day for days 91 and beyond 	• \$300 copay per stay You 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.
0 1 1:	. 1 1 (1 ()	1 .

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

Prior authorization may be required.

\$150 copay per day	\$100 copay per day	\$75 copay per day
\$150 copay per day	\$100 copay per day	\$75 copay per day

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

Prior authorization may be required.

OUTPATIENT CARE AND SERVICES	Basic No Rx	Basic Rx
OUTFATIENT CAKE AND SERVICES		
\$10 copay per visit	\$10 copay per visit	
\$45 copay per visit	\$40 copay	y per visit
1 .	•	•
You pay nothing	You pa	y nothing
• • •		ledicare
\$90 copay per visit	\$110 cop	ay per visit
you do not have to pay your share	are of the cost for emergency care.	
vices		,
\$10 copay per PCP visit \$45 copay per Specialist visit		er PCP visit Specialist visit
providers when network providers are	temporarily unavailabl	e or inaccessible.
Labs/Imaging		
\$325 copay per day	\$250 copa	ay per day
\$100 per day for ultrasound	\$100 per day t	for ultrasound
\$10 per day per provider	\$10 per day per provider	
\$10 per day per provider	\$10 per day	per provider
\$10 per day per provider	\$10 per day	per provider
Outpatient X-rays \$10 per day per provider \$10 per day per provider What You Should Know the services are performed as part of an office visit. Prior authorization may be required.		
	\$45 copay per visit There is no copay for an annual physical services from a specialist, you must you pay nothing Any additional preventive set during the contract during the contract services. \$90 copay per visit If you are admitted to the you do not have to pay your shat Your plan includes worldwide vices \$10 copay per PCP visit \$45 copay per Specialist visit Urgently needed care may be furnished by providers when network providers are Your plan includes worldwide contabs/Imaging \$325 copay per day \$100 per day for ultrasound \$10 per day per provider \$10 per day per provider \$10 per day per provider \$10 per day per provider	\$45 copay per visit \$40 copay There is no copay for an annual physical exam with your PCP. services from a specialist, you must obtain a referral from You pay nothing You pa Any additional preventive services approved by M during the contract year will be covered. \$90 copay per visit \$110 cop If you are admitted to the hospital within 24 ho you do not have to pay your share of the cost for emerge Your plan includes worldwide coverage for emergen vices \$10 copay per PCP visit \$10 copay per \$45 copay per Specialist visit \$40 copay per Urgently needed care may be furnished by in-network providers are temporarily unavailable Your plan includes worldwide coverage for urgently needed. **Sopay** per day \$250 copay** per day \$250 copay** per day for ultrasound \$100 per day in \$100 per day \$100 per day \$10 per da

| Tufts Medicare
Preferred HMO |
|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
| Value No Rx | Value Rx | Prime No Rx | Prime Rx | Prime Rx Plus |
| | | | | |
| | | | | |
| \$10 copa | y per visit | | \$10 copay per visit | |
| \$25 copa | y per visit | | \$15 copay per visit | |
| There is | s no copay for an annu | al physical exam with | your PCP. Before you | receive |
| S | ervices from a speciali | st, you must obtain a 1 | referral from your PCI | P |
| | | | | |
| You pa | y nothing | | You pay nothing | |
| | Any additional p | reventive services app | roved by Medicare | |
| | during t | he contract year will b | e covered. | |
| | | | | |
| \$110 cop | ay per visit | | \$110 copay per visit | |
| | If you are adm | itted to the hospital w | ithin 24 hours, | |
| | | | st for emergency care. | |
| | Your plan includes | worldwide coverage f | or emergency care. | |
| | | | | |
| \$10 copay p | er PCP visit | \$ | 810 copay per PCP visi | t |
| \$25 copay per | Specialist visit | \$15 | s copay per Specialist v | risit |
| Urgently | needed care may be fu | ırnished by in-network | x providers or by out-o | f-network |
| provid | ders when network pro | oviders are temporarily | y unavailable or inacce | ssible. |
| | Your plan includes w | orldwide coverage for | urgently needed care. | |
| | | | | |
| \$100 copa | ay per day | | 20% of the cost | |
| | | You will n | ot pay more than \$75 | per day for |
| | | diaş | gnostic radiology servi | ces. |
| \$5 per day 1 | per provider | | You pay nothing | |
| ψο per day j | provider | | Tou pay nouning | |
| \$5 per day p | per provider | | You pay nothing | |
| \$5 per day p | per provider | | You pay nothing | |
| No copay for diag | gnostic tests and proce | dures, lab services, and | • | the services are per- |

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.

	Tufts Medicare Preferred HMO Saver Rx	Tufts Medicare Preferred HMO Basic No Rx	Tufts Medicare Preferred HMO Basic Rx
NPATIENT AND	OUTPATIENT CARE AND SERVICES		
Hearing Services			
Exam to diagnose and treat hearing and balance issues	\$45 copay per visit	\$40 copa	y per visit
Routine hearing exam (up to 1 every year)	\$45 copay per visit	\$40 copar	y per visit
Hearing aids	Standard level:	Standar	rd level:
	\$250 copay per hearing aid	\$250 copay po	er hearing aid
	Superior level:	Superio	or level:
	\$475 copay per hearing aid	\$475 copay p	er hearing aid
	Advanced level:		ed level:
	\$650 copay per hearing aid	1 , 1	er hearing aid
	Advanced Plus level:		Plus level:
	\$850 copay per hearing aid		er hearing aid
	Premier level:	Premie	er level:
		φ1 150 ·····	1 1
What Vou	\$1,150 copay per hearing aid		per hearing aid
What You Should Know		im from a specialist, yong aids through Hearin	ou must obtain a referral ng Care Solutions to
	\$1,150 copay per hearing aid Before you receive a diagnostic hearing exa from your PCP. You must purchase hearing	im from a specialist, yong aids through Hearin	ou must obtain a referral ng Care Solutions to
Should Know	\$1,150 copay per hearing aid Before you receive a diagnostic hearing exa from your PCP. You must purchase hearing	um from a specialist, yong aids through Hearing aids per year, 1	ou must obtain a referral ng Care Solutions to
Should Know Dental Limited Medicare-covered	\$1,150 copay per hearing aid Before you receive a diagnostic hearing exa from your PCP. You must purchase hearing receive the Hearing Aid benefit. Up to 2 h	am from a specialist, young aids through Hearing aids per year, 1 \$40 copar	ou must obtain a referral ng Care Solutions to hearing aid per ear. y per visit ntive dental services
Should Know Dental Limited Medicare-covered Dental Services What You	\$1,150 copay per hearing aid Before you receive a diagnostic hearing exa from your PCP. You must purchase hearing receive the Hearing Aid benefit. Up to 2 h \$45 copay per visit Limited Medicare-covered dental services	s do not include prevental exams, and dental You pay nothing for and diagnostic exam	ou must obtain a referral ng Care Solutions to hearing aid per ear. y per visit ntive dental services
Should Know Dental Limited Medicare-covered Dental Services What You Should Know Preventive	\$1,150 copay per hearing aid Before you receive a diagnostic hearing example from your PCP. You must purchase hearing receive the Hearing Aid benefit. Up to 2 hearing and benefit with the services are such as cleaning, routine denoted and diagnostic exams and services. You	s do not include prevental exams, and dental You pay nothing for and diagnostic exampay 50% for rest	y per visit ntive dental services X-rays. r routine preventive ns and services. You torative services.
Should Know Dental Limited Medicare-covered Dental Services What You Should Know Preventive Dental benefit What You	\$1,150 copay per hearing aid Before you receive a diagnostic hearing exargory from your PCP. You must purchase hearing receive the Hearing Aid benefit. Up to 2 hearing and benefit. Up to 2 hearing are such as cleaning, routine denoted as cleaning, routine denoted and diagnostic exams and services. You pay 50% for restorative services. Coverage is limited to providers to the company 50% for restorative services.	s do not include prevental exams, and dental You pay nothing for and diagnostic exampay 50% for rest within the Dominion Particular of the preventation of the preventation of the pay 50% for rest within the Dominion Particular of the preventation of the pay 50% for rest within the Dominion Particular of the pay 50% for rest within the Dominion Particular of the pay 50% for rest within the Dominion Particular of the pay 50% for rest within the Dominion Particular of the pay 50% for rest within the Dominion Particular of the pay 50% for rest within the pay 50% for rest within the Dominion Particular of the pay 50% for rest within the Dominion Particular of the pay 50% for rest within the pay 50%	nu must obtain a referral ng Care Solutions to hearing aid per ear. y per visit ntive dental services X-rays. r routine preventive ns and services. You torative services. PPO network.
Should Know Dental Limited Medicare-covered Dental Services What You Should Know Preventive Dental benefit What You Should Know Tufts Health Plan Medicare Preferred Dental	\$1,150 copay per hearing aid Before you receive a diagnostic hearing exargement from your PCP. You must purchase hearing receive the Hearing Aid benefit. Up to 2 hearing and benefit. Up to 2 hearing are such as cleaning, routine denoted as cleaning, routine denoted and diagnostic exams and services. You pay 50% for restorative services. Coverage is limited to providers to Covered with additional company and services.	s do not include prevental exams, and dental You pay nothing for and diagnostic exampay 50% for rest within the Dominion Particular of the preventation of the preventation of the pay 50% for rest within the Dominion Particular of the preventation of the pay 50% for rest within the Dominion Particular of the pay 50% for rest within the Dominion Particular of the pay 50% for rest within the Dominion Particular of the pay 50% for rest within the Dominion Particular of the pay 50% for rest within the Dominion Particular of the pay 50% for rest within the pay 50% for rest within the Dominion Particular of the pay 50% for rest within the Dominion Particular of the pay 50% for rest within the pay 50%	nu must obtain a referral ng Care Solutions to hearing aid per ear. y per visit ntive dental services X-rays. r routine preventive ns and services. You torative services. PPO network.

Tufts Medicare	Tufts Medicare	Tufts Medicare	Tufts Medicare	Tufts Medicare
Preferred HMO	Preferred HMO	Preferred HMO	Preferred HMO	Preferred HMO
Value No Rx	Value Rx	Prime No Rx	Prime Rx	Prime Rx Plus
\$25 copa	y per visit		\$15 copay per visit	
\$25 cops	y per visit		\$15 copay per visit	
Ф23 с ора	y per visit		\$13 copay per visit	
Standar	rd level:		Standard level:	
\$250 copay p	er hearing aid	\$2	50 copay per hearing a	aid
Superio	or level:	Superior level:		
\$475 copay p	er hearing aid	\$475 copay per hearing aid		
Advanc	ed level:	Advanced level:		
\$650 copay p	er hearing aid	\$650 copay per hearing aid		
Advanced	Plus level:	Advanced Plus level:		
\$850 copay p	er hearing aid	\$850 copay per hearing aid		
Premie	er level:	Premier level:		
\$1,150 copay p	per hearing aid	\$1,150 copay per hearing aid		
Before you receive a	a diagnostic hearing ex	am from a specialist,	ou must obtain a refe	rral from your PCP.
You must purchase h	nearing aids through H	Iearing Care Solutions	to receive the Hearing	g Aid benefit. Up to 2
	hearing ai	ds per year, 1 hearing a	aid per ear.	
\$25 copay per visit			\$15 copay per visit	
Limited Medicar	e-covered dental servi	ces do not include pre	ventive dental services	such as cleaning,
	routine d	ental exams, and dent	al X-rays.	
Not c	overed		Not covered	
		1		

Covered with additional premium.
See the Optional Benefits section for more information.

N/A

\$15 copay per visit	\$15 copay per visit

	Tufts Medicare Preferred HMO Saver Rx	Tufts Medicare Preferred HMO Basic No Rx	Tufts Medicare Preferred HMO Basic Rx
	OUTPATIENT CARE AND SERVICES		
Vision Services con	tinued 	T	
Exam to diagnose and treat diseases and conditions of the eye	\$45 copay per visit	\$40 copa	y per visit
Annual glauco- ma screening	\$0 copay per visit	\$0 copay	per visit
Annual eyewear benefit	Up to \$150 allowance per calendar year	Up to \$150 allowan	ce per calendar year
What You Should Know	You must use a participating vision care the covered Routine Eye Exam benefit. prescription lenses, or contacts from a particitor receive the \$150 allowance. Otherwise, You need a referral from your	You must purchase you ipating vision provider (the benefit will be limit	ur glasses, frames, EyeMed Vision Care) ited to \$90 per year.
Mental Health Servi		1 C1 101 a diagnostic c	ye exam.
Inpatient visit	 \$315 copay per day for days 1 through 5 You pay nothing per day for days 6 through 90 	 \$275 copay per day for days 1 thro You pay nothing per day for days 6 through 90 	
Outpatient group or individual therapy visit	\$25 copay per visit	\$25 copay per visit	
What You Should Know	Our plan covers up to 190 days in a line in a psychiatric hospital. The inpatient inpatient mental health services. Our plan covers 90 days for Our plan also covers 60 "lifetime reserve of If your hospital stay is longer than 90 days, have used up these extra 60 days, your inpatient group our plan are good of the service outpatient group our must obtain a reserve outpatient group must obtain a reserve outpatient group must obtain a reserve outpatient group our must obtain a reserve outpatient group must obtain a reserv	nt hospital care limit do s provided in a general or an inpatient hospital days." These are "extra" s you can use these extrent hospital coverage wil	nes not apply to hospital. stay. days that we cover. a days. But once you like limited to 90 days
Skilled Nursing Fac	ility (SNF)		
	• \$0 copay per day for days 1 through 20	• \$20 copay per day for	
	 \$160 copay per day for days 21 through 44 \$0 copay per day for days 45 through 100 	• \$140 copay per day fo	

\$25 copay per visit \$0 copay per visit \$15 copay per visit \$25 copay per day for days 1 through 5 \$26 You will not pay more than \$900 for	Tufts Medicare	Tufts Medicare	Tufts Medicare	Tufts Medicare	Tufts Medicare
\$25 copay per visit \$0 copay per visit \$0 copay per visit \$0 copay per visit Up to \$150 allowance per calendar year You must use a participating vision care provider (EyeMed Vision Care) to receive the covered Routine Eye Exam benefit. You must purchase your glasses, 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. \$200 copay per day for days 1 through 5 You will not pay more than \$900 for more than \$900 for inpatient hospital covered services in a calendar year. \$25 copay per visit \$15 copay per visit \$25 copay per visit Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental health services provided in a general hospital.					Preferred HMO Prime Rx Plus
\$0 copay per visit \$0 copay per visit Up to \$150 allowance per calendar year You must use a participating vision care provider (EyeMed Vision Care) to receive the covered Routine Eye Exam benefit. You must purchase your glasses, 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. \$200 copay per day for days 1 through 5 You will not pay more than \$900 for inpatient hospital covered services in a calendar year. \$25 copay per visit \$15 copay per visit Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental health services provided in a general hospital.	value 140 KA	v aruc RA	Time No Rx	1 Time RX	Time RX Tius
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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. \$200 copay per day for days 1 through 5 You will not pay For a diagnostic eye exam. \$200 copay per day for days 1 through 5 You will not pay For a diagnostic eye exam. \$200 copay per stay. You will not pay For a diagnostic eye exam. \$200 copay per stay. You will not pay For a diagnostic eye exam. \$200 copay per stay. You will not pay For a diagnostic eye exam. \$200 copay per stay. You will not pay For a diagnostic eye exam. \$200 copay per stay. You will not pay For a diagnostic eye exam.	\$25 copay	per visit		\$15 copay per visit	
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. \$200 copay per day for days 1 through 5 You will not pay For a diagnostic eye exam. \$200 copay per day for days 1 through 5 You will not pay For a diagnostic eye exam. \$200 copay per stay. You will not pay For a diagnostic eye exam. \$200 copay per stay. You will not pay For a diagnostic eye exam. \$200 copay per stay. You will not pay For a diagnostic eye exam. \$200 copay per stay. You will not pay For a diagnostic eye exam. \$200 copay per stay. You will not pay For a diagnostic eye exam.	\$0 copay	ner vicit		\$0 copay per vicit	
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. \$200 copay per day for days 1 through 5 You will not pay 6 through 90 Town will not pay 7 you will not pay 8 more than \$900 for more the inpatient hospital covered services in a calendar year. \$25 copay per visit \$15 copay per visit Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental health services provided in a general hospital.	ъо сорау	per visit		so copay per visit	
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. \$200 copay per day for days 1 through 5 You will not pay for through 90	Up to \$150 allowance	e per calendar year	Up to \$1	50 allowance per cale	ndar year
You pay nothing per day for days 6 through 90 Strong per day for days 6 through 90 Strong per day for days 6 through 90 Strong per day for days 825 copay per visit Strong per visit Strong per visit Superior pay 825 copay per visit Strong per visit Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental health services provided in a general hospital.	to receive				per year.
6 through 90 more than \$900 for inpatient hospital covered services in a calendar year. a cale \$25 copay per visit \$15 copay per visit Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental health services provided in a general hospital.	\$200 copay per day	for days 1 through 5	\$300 copa	y per stay.	\$200 copay per stay
inpatient hospital covered services in a calendar year. Substitute of the services of a calendar year. Substitute of the services of a calendar year. Substitute of the services of the ser		r day for days			You will not pay
\$25 copay per visit Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental health services provided in a general hospital.	6 through 90				more than \$400 for
\$25 copay per visit Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental health services provided in a general hospital.			_	_	inpatient hospital covered services in
\$25 copay per visit Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental health services provided in a general hospital.					a calendar year.
in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental health services provided in a general hospital.	\$25 copay	per visit			,
in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental health services provided in a general hospital.	Our r	plan covers up to 190	davs in a lifetime for i	npatient mental health	ı care
	=	osychiatric hospital. T	he inpatient hospital c	care limit does not app	
Our plan covers 90 days for an inpatient hospital stay.		Our plan covers	90 days for an inpatie	ent 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 yo	<u>-</u>			•	

Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.

Before you receive outpatient group or individual therapy visits, you must obtain a referral from your PCP.

• \$20 copay per day for days 1 through 20	• \$20 copay per day for days 1 through 20	• \$20 copay per day for
• \$100 copay per day for days 21 through 44	• \$60 copay per day for days 21 through 44	days 1 through 20
• \$0 copay per day for days 45 through 100	• \$0 copay per day for days 45 through 100	• \$0 copay per day for
		days 21 through 100

Our plan covers up to 100 days in a SNF.

	Tufts Medicare Preferred HMO Saver Rx	Tufts Medicare Preferred HMO Basic No Rx	Tufts Medicare Preferred HMO Basic Rx				
	OUTPATIENT CARE AND SERVICESS						
Physical Therapy							
Occupational therapy	\$40 copay per visit	\$40 copay per visit \$30 copay per visit					
Physical therapy and speech and language therapy	\$40 copay per visit	\$30 cop	ay per visit				
What You Should Know	Before you receive occupational therapy, therapy services, you must ob						
Ambulance							
	\$350 copay per trip	\$325 copa	ay per trip				
Transportation							
	\$40 copay per ride	\$40 copa	y per ride				
What You Should Know	Non-ambulance transportation (e.g., by cha plan-approved vendor from a hospital to a dischargin	skilled nursing facility					
Medicare Part B Dr	ugs						
	For Part B drugs such as chemotherapy drugs: You pay 20% of the cost. Other Part B drugs: You pay 20% of the cost.	chemother You pay 209 Other Par	rugs such as rapy drugs: 6 of the cost. 7 B drugs: 6 of the cost.				
What You Should Know	Prior authorization	n may be required.					

Tufts Medicare Preferred HMO Value No Rx	Tufts Medicare Preferred HMO Value Rx	Tufts Medicare Preferred HMO Prime No Rx	Tufts Medicare Preferred HMO Prime Rx	Tufts Medicare Preferred HMO Prime Rx Plus			
\$20 copay per visit \$15 copay per visit							
\$20 copa	ny per visit		\$15 copay per visit				
Before you receive occupational therapy, physical therapy, or speech and language therapy services, you must obtain a referral from your PCP.							
\$225 copa	ny per day	\$125 copa	ny per day	\$90 copay per day			
\$40 copa	y per ride		\$40 copay per ride				
	ransportation (e.g., by a hospital to a skilled i						
	rugs such as	F	or Part B drugs such a	ns			
	apy drugs:		chemotherapy drugs:				
You pay	nothing.	You pay nothing.					
Other Par	O	Other Part B drugs:					
You pay	nothing.		You pay nothing.				

Prior authorization may be required.

	Tufts Medicare Preferred HMO Saver Rx	Tufts Medicare Preferred HMO Basic No Rx	Tufts Medicare Preferred HMO Basic Rx	Tufts Medicare Preferred HMO Value No Rx	Tufts Medicare Preferred HMO Value Rx	Tufts Medicare Preferred HMO Prime No Rx	Tufts Medicare Preferred HMO Prime Rx
PRESCRIPTION DE Initial Coverage	RUG BENEFITS						
	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 \$4,020. 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 \$4,020. 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 \$4,020. 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 until you yearly do reach Total yearly do costs are drug costs both you Part I You may drugs at retail phand may phare

Summary of Benefits 14

Tufts Medicare

Preferred HMO

Prime Rx Plus

You pay the following until your total yearly drug costs reach \$4,020. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.

Tufts Medicare	Tufts Medicare
Preferred HMO	Preferred HMO
Saver Rx	Basic Rx

PRESCRIPTION DRUG BENEFITS

Initial Coverage

15

Standard 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

Standard 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

Tufts Medicare	Tufts Medicare	Tufts Medicare
Preferred HMO	Preferred HMO	Preferred HMO
Value Rx	Prime Rx	Prime Rx Plus

One- month supply	Two- month supply	Three- month supply	One- month supply	Two- month supply	Three- month supply	One- month supply	Two- month supply	Three- month supply
\$4	\$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

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	N/A	N/A	N/A

	Tufts Medicare	Tufts Medicare
	Preferred HMO	Preferred HMO
	Saver Rx	Basic Rx
PRESCRIPTION DRUG BEN	FFITS	·

Standard Mail Order Cost Sharing

Tier	One- month supply	Two- month supply	Three- month supply	One- month supply	Two- month supply	Three- month supply
Tier 1 (Preferred Generic)	\$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 and Tier 2 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 and Tier 2 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 Medicare				
Preferred HMO				
Value Rx				

Tufts Medicare Preferred HMO Prime Rx

Tufts Medicare Preferred HMO Prime Rx Plus

One- month supply	Two- month supply	Three- month supply	One- month supply	Two- month supply	Three- month supply	One- month supply	Two- month supply	Three- month supply
\$4	\$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 and Tier 2 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.

If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

	Tufts Medicare Preferred HMO Saver Rx	Tufts Medicare Preferred HMO Basic Rx					
DDECODID	DDDGCDIDELON DDIVC DDVDELEG						

PRESCRIPTION DRUG BENEFITS

Coverage Gap

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$4,020. 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 \$6,350, 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 \$4,020. 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 \$6,350, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Tufts Medicare Preferred HMO Value Rx

Tufts Medicare Preferred HMO Prime Rx

Tufts Medicare Preferred HMO Prime Rx Plus

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$4,020. 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 \$6,350, which is the end of the coverage gap.

Not everyone will enter

the coverage gap.

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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 \$6,350, 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 \$4,020.

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 \$6,350, 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.

Preferred HMO Saver Rx	Tufts Medicare Preferred HMO Basic Rx	Tufts Medicare Preferred HMO Value Rx	Tufts Medicare Preferred HMO Prime Rx		Tufts M Preferre Prime	ed HMO	
PRESCRIPTION DRUG BENEFITS							
Coverage Gap							
					d Retail (
				Drug Covered	One- month supply	Two- month supply	
				Tier 1 (I	Preferred	Generic)
				All	\$2	\$4	\$6
				Tier 2 (0	Generic)		
				All	\$4	\$8	\$12
				Standard	d Mail Or	der Cost	Sharing
				Drug	One-	Two-	Three
				Covered	supply	month supply	
				`	Preferred	Generic	1
				All	\$2	\$4	\$4
				Tier 2 (0	Generic)	L	
				All	\$4	\$8	\$8
Catastrophic Coverage							
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$6,350, you pay the greater of: • 5% of the cost, or • \$3.60 copay for generic (including brand drugs treated as generic) and	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$6,350, you pay the greater of: • 5% of the cost, or • \$3.60 copay for generic (including brand drugs treated as generic) and a \$8.95 copayment for	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$6,350, you pay the greater of: • 5% of the cost, or • \$3.60 copay for generic (including brand drugs treated as generic) and a \$8.95 copayment for	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$6,350, you pay the greater of: • 5% of the cost, or • \$3.60 copay for generic (including brand drugs treated as generic) and a \$8.95 copayment for	drug co purcha pharma order): the grea • 5% of • \$3.60 (inclu	our yearly osts (inclused throused and the reach \$6,5 ater of: The cost, copay for ding brand as gene	iding drugh your nrough n 350, you or r generic d drugs ric) and	igs retail nail pay

	Tufts Medicare Preferred HMO Saver Rx	Tufts Medicare Preferred HMO Basic No Rx	Tufts Medicare Preferred HMO Basic Rx	
OPTIONAL BENE	EFITS (You must pay an extra premium eac	h month for these ber	nefits)	
Tufts Health Plan	Medicare Preferred Dental Option	_		
	Benefits include: • Preventive Dental • Comprehensive Dental	Benefits include: • Preventive Dental • Comprehensive Dental		
Monthly Premiun	n	_		
	Additional \$17.00 per month.		nal \$17.00 month.	
What You Should Know	You must keep paying you and your mont	ur Medicare Part B pre hly plan premium.	mium	
Deductible				
	This plan does not have a deductible.	This plan does not	t have a deductible.	
The Plan offers th	e following benefits:			
	 Routine preventive services covered at 100%. You pay \$0. Fillings and simple extractions covered at 80%. You pay 20%. Root canals, dentures, and crowns covered at 50%. You pay 50%. 	 Routine preventive at 100%. You pay \$0 Fillings and simple at 80%. You pay 200 Root canals, denture covered at 50%. You 	O. extractions covered %. es, and crowns	
What You Should Know	Coverage is limited to providers within the Dominion PPO network.			
ADDITIONAL B	ENEFITS			
Acupuncture				
Acupuncture services when provided by a licensed acupuncturist	Acupuncture services are eligible f Wellness Allowance benefit. See addition			

Tufts Medicare Preferred HMO

Tufts Medicare Preferred HMO Value No Rx	Tufts Medicare Preferred HMO Value Rx	Tufts Medicare Preferred HMO Prime No Rx	Tufts Medicare Preferred HMO Prime Rx	Tufts Medicare Preferred HMO Prime Rx Plus		
Benefits incl • Preventive			its include: ventive Dental			
	ensive Dental		nprehensive Dental			
		I.				
Additional \$30.00 Additional \$30.00						
per i	month.		per month.			
	You must keep	paying your Medicare	e Part B premium			
	and	your monthly plan pre	emium.			
This plan does not	t have a deductible.	This pla	an does not have a dec	luctible.		
• Routine preventive	services covered	• Routine preventive	services covered			
at 100%. You pay \$6		at 100%. You pay \$0.				
• Fillings and simple		• Fillings and simple				
at 80%. You pay 20% • Root canals, dentur		at 80%. You pay 209		d at 50% Vou pay		
· ·	• Root canals, dentures, and crowns covered at 50%. You pay 50%. • Root canals, dentures, and crowns covered at 50%. You pay 50%.					
		e is limited to provider				
		Dominion PPO netwo	rk. —————————			

Acupuncture services are eligible for reimbursement under the annual Wellness Allowance benefit. See additional details under "Wellness Programs".

	Tufts Medicare Preferred HMO Saver Rx	Tufts Medicare Preferred HMO Basic No Rx	Tufts Medicare Preferred HMO Basic Rx
ADDITIONAL BEI	NEFITS		
Chiropractic Care		I	
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	
Initial evaluation (once per year)	\$15 copay	\$15 (copay
What You Should Know	Before you receive services from a specialist	t, you must obtain a re	ferral from your PC
Foot Care (podiatry	services)		
Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions	\$45 copay per visit	\$40 copay per visit	
What You Should Know	Before you receive services from a specialist	t, you must obtain a re	ferral from your PC
Home Health Service	ces		
Home health agency care	You pay nothing	You pay	nothing
Home health infusion therapy	You pay nothing	You pay	nothing
What You Should Know	Prior authorization	on may be required.	
Hospice			
	You pay nothing	You pay	nothing
What You Should Know	You may have to pay part of the Hospice is covered outside of our pla	•	•

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Tufts Medicare Preferred HMO

Tufts Medicare Preferred HMO Value No Rx	Tufts Medicare Preferred HMO Value Rx	Tufts Medicare Preferred HMO Prime No Rx	Tufts Medicare Preferred HMO Prime Rx	Tufts Medicare Preferred HMO Prime Rx Plus			
\$15 copa	y per visit		\$15 copay per visit				
\$15 (copay		\$15 copay				
Before you	ı receive services from	m a specialist, you must obtain a referral from your PCP.					
\$25 copa	y per visit	\$15 copay per visit					
Before you	ı receive services from	a specialist, you must	obtain a referral from	your PCP.			
You pay	nothing		You pay nothing				
You pay	You pay nothing		You pay nothing				
	Prior a	uthorization may be 1	required.				
You pay	nothing		You pay nothing				
		part of the costs for d e of our plan. Please co	rugs and respite care.	ails.			

	Tufts Medicare Preferred HMO Saver Rx	Tufts Medicare Preferred HMO Basic No Rx	Tufts Medicare Preferred HMO Basic Rx		
ADDITIONAL BE	NEFITS				
Medical Equipment	/Supplies				
Durable medical equipment (e.g., wheelchairs, oxygen)	20% of the cost 20% of the cost				
Prosthetic devices (braces, artificial limbs, etc.)	20% of the cost	20% of	the cost		
What You Should Know	Items covered by the plan: bathroom safety have a functional impairment when having • Standard raised toilet seat: 1 per member • Standard bathroom grab bars: 2 per membe • Standard tub seat: 1 per member every five the following additional items are covered • Gradient compression stockings or surgioup to 2 pair every 6 months • Mastectomy sleeves for members with up up to 2 pair every 6 months Prior authorization may be required.	the item will improve every five years revery five years by the plan: cal stockings:	safety:		
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 therapeutic shoes or inserts. Copay may apply the same office visit. Referral required for decoverage for blood glucose monitors, blood solutions is limited to the One Touch produced Please note that there is no preferred branch	y if you receive other maliabetes self-management d glucose tests strips, a ucts manufactured by	edical services during ent training only. nd glucose-control		
Outpatient Substan	ce Abuse				
Group or individual therapy visit	\$25 copay per visit	\$25 copa	y per visit		
What You Should Know	Before you receive services from a specialist	, you must obtain a re	ferral from your PCP.		
Renal Dialysis					
	20% of the cost	20% of	the cost		
			icare Preferred HMC		

Tufts Medicare Preferred HMO Value No Rx	Tufts Medicare Preferred HMO Value Rx	Tufts Medicare Preferred HMO Prime No Rx	Tufts Medicare Preferred HMO Prime Rx	Tufts Medicare Preferred HMO Prime Rx Plus		
10% of	the cost		10% of the cost			
10% of	the cost		10% of the cost			
have a f • Standa • Standa • Standa The foll • Gradio up to 2 • Maste up to 2	overed by the plan: bate unctional impairment and raised toilet seat: 1 and bathroom grab bars: and tub seat: 1 per men owing additional items ent compression stocki 2 pair every 6 months ctomy sleeves for mem 2 pair every 6 months athorization may be recovery	when having the item per member every five 2 per member every five ber every five years are covered by the plangs or surgical stockir abers with upper limb	will improve safety: e years e years an: ngs: lymphedema:			
	oer year v nothing		\$500 per year You pay nothing			
Include therapeu the sam Coveraş solution	s diabetes monitoring satic shoes or inserts. Cope office visit. Referral rege for blood glucose mass is limited to the One note that there is no presented.	pay may apply if you re equired for diabetes so onitors, blood glucose. Touch products man	management training, ceive other medical ser elf-management traini tests strips, and gluco ufactured by Lifescan,	vices during ng only. se-control		
\$25 copa	y per visit		\$15 copay per visit			
Before you	ı receive services from	a specialist, you must	obtain a referral from	your PCP.		
20% of	the cost	20% of the cost				

	Tufts Medicare Preferred HMO Saver Rx	Tufts Medicare Preferred HMO Basic No Rx	Tufts Medicare Preferred HMO Basic Rx		
ADDITIONAL BEI			2 0000 2 000		
Wellness Programs					
Weight Management Program	The plan provides a \$150 annual weight management allowance towards program fees for weight loss programs such as WeightWatchers®, Jenny Craig®, or a hospital-based weight loss program.				
Wellness Allowance	The plan provides a \$300 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.	wellness allowance memberships, nut acupuncture, or Pilates, Tai Cl and wellness pro	es a \$150 annual toward health club ritional counseling, fitness classes like hi, or aerobics, ograms, including ess activities.		
SilverSneakers®		of Worcester County only. dicare Preferred HMO Saver Rx.			
	SilverSneakers encourages physical exercise equipment, and other amenities. A and access to over 14,000 participating loc to get the activity you	Members receive a basi	c fitness membershi		

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

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 wellness allowance toward health club memberships, nutritional counseling, acupuncture, or fitness classes like Pilates, Tai Chi, or aerobics, and wellness programs, including memory fitness activities.

Applicable to residents of Worcester County only. Not Applicable to Tufts Medicare Preferred HMO Saver Rx.

SilverSneakers encourages physical activity by offering access to classes, exercise equipment, and other amenities. Members receive a basic fitness membership and access to over 14,000 participating locations. SilverSneakers offers different ways to get the activity you need to stay healthy.

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

Tufts Health Plan:

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

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

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

Tufts Health Plan, Attention:

Civil Rights Coordinator, Legal Dept.

705 Mount Auburn St., Watertown, MA 02472

Phone: 1-888-880-8699 ext. 48000 (TTY: 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.

www.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 9000-701-800-1 (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. (TTY: 711) 1800-701-800-1 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 ដោយមិនគិតឈ្នូល 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 yánílti'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 (ТТҮ: 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).

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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).

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QUESTIONS?

Call 1-888-515-5880 // TTY: 711

VISIT US AT: www.thpmp.org

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

This information is not a complete description of benefits. Call 1-800-701-9000 (TTY: 711) for more information.

Dental benefits are administered by Dominion Dental Services, Inc., which operates under the trade name Dominion National. For questions regarding your benefits or provider network, please contact Customer Relations.

