TUFTS MEDICARE PREFERRED HMO SUMMARY OF BENEFITS #H2256

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

Look Inside

Effective January 1, 2012–December 31, 2012

H2256_2012_1R1 CMS Approved [XX/XX/2011]

TUFTS Health Plan Medicare Preferred

Introduction to the Summary of Benefits Report for Tufts Medicare Preferred HMO (HMO) Plans

January 1, 2012 - December 31, 2012

Most of Massachusetts

Thank you for your interest in Tufts Medicare Preferred HMO (HMO) plans. Our plans are offered by TUFTS ASSOCIATED HMO, INC./ Tufts Health Plan Medicare Preferred, a Medicare Advantage Health Maintenance Organization (HMO). This Summary of Benefits tells you some features of our plans. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Tufts Health Plan Medicare Preferred and ask for the "Evidence of Coverage".

You Have Choices In Your Health Care

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like Tufts Medicare Preferred HMO (HMO). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may join or leave a plan only at certain times. Please call Tufts Health Plan Medicare Preferred at the telephone number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY/TDD users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

How Can I Compare My Options?

You can compare Tufts Medicare Preferred HMO (HMO) plans and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

Where Are Tufts Medicare Preferred HMO (HMO) Plans Available?

There is more than one plan listed in this Summary of Benefits. If you are enrolled in one plan and wish to switch to another plan, you may do so only during certain times of the year. Please call Customer Service for more information. The service area for these plans include the following counties: Barnstable, Bristol*, Essex, Hampden, Hampshire, Middlesex, Norfolk, Plymouth*, Suffolk, and Worcester Counties, MA. You must live in one of these areas to join a Tufts Medicare Preferred HMO (HMO) plan. Asterisk (*) indicates partial county.

Who Is Eligible To Join Tufts Medicare Preferred HMO (HMO) Plans?

You can join our Tufts Medicare Preferred HMO (HMO) plans if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End Stage Renal Disease are generally not eligible to enroll in Tufts Medicare Preferred HMO (HMO) plans unless they are members of our organization and have been since their dialysis began.

Can I Choose My Doctors?

Tufts Health Plan Medicare Preferred has formed a network of doctors, specialists, and hospitals. You can only use doctors who are part of our network. The health providers in our network can change at any time. You can ask for a current Provider Directory. For an updated list, visit us at tuftsmedicarepreferred.org.

Our customer service number is listed at the end of this introduction.

What Happens If I Go To A Doctor Who's Not In Your Network?

If you choose to go to a doctor outside of our network, you must pay for these services yourself except in limited situations (for example, emergency care). Neither the plan nor the Original Medicare Plan will pay for these services.

Where Can I Get My Prescriptions If I Join One of These Plans?

Tufts Health Plan Medicare Preferred has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at tuftsmedicarepreferred.org/druglist. Our customer service number is listed at the end of this introduction.

Does My Plan Cover Medicare Part B Or Part D Drugs?

Tufts Medicare Preferred HMO Basic (HMO), Tufts Medicare Preferred HMO Value (HMO) and Tufts Medicare Preferred HMO Prime (HMO) does cover Medicare Part B prescription drugs but do NOT cover Medicare Part D prescription drugs.

Tufts Medicare Preferred HMO Basic Rx (HMO), Tufts Medicare Preferred HMO Value Rx (HMO), Tufts Medicare Preferred HMO Prime Rx (HMO) and Tufts Medicare Preferred HMO Prime Rx Plus (HMO) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

What Is A Prescription Drug Formulary?

Tufts Medicare Preferred HMO Basic Rx (HMO), Tufts Medicare Preferred HMO Value Rx (HMO), Tufts Medicare Preferred HMO Prime Rx (HMO) and Tufts Medicare Preferred HMO Prime Rx Plus (HMO) use a formulary.

Tufts Medicare Preferred HMO (HMO) plans use a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our website at tuftsmedicarepreferred.org/druglist.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

How Can I Get Extra Help With My Prescription Drug Plan Costs Or Get Extra Help With Other Medicare Costs?

You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare costs. To see if you qualify for getting extra help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week; and see www.medicare.gov 'Programs for People with Limited Income and Resources' in the publication Medicare & You.
- The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778; or
- Your State Medicaid Office

What Are My Protections In This Plan?

All Medicare Advantage Plans agree to stay in the program for a full calendar year at a time. Plan benefits and cost-sharing may change from calendar year to calendar year. Each year, plans can decide whether to continue to participate with Medicare Advantage. A plan may continue in their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also, Medicare may decide to end a contract with a plan. Even if your Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue for an additional calendar year, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of a Tufts Medicare Preferred HMO (HMO) plan, you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

As a member of a Tufts Medicare Preferred HMO (HMO) plan, you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules,

such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

What Is A Medication Therapy Management (MTM) Program?

A Medication Therapy Management (MTM) Program is a free service we offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact Tufts Health Plan Medicare Preferred for more details.

What Types Of Drugs May Be Covered Under Medicare Part B?

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact Tufts Health Plan Medicare Preferred for more details.

- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.
- Erythropoietin (Epoetin Alpha or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.
- Injectable Drugs: Most injectable drugs administered incident to a physician's service.
- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- Some Oral Cancer Drugs: If the same drug is available in injectable form.
- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.
- Inhalation and infusion drugs administered through DME.

Where Can I Find Information on Plan Ratings

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on www.medicare.gov and select "Health and Drug Plans" then "Compare Drug and Health Plans" to compare the plan ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the plan ratings for this plan. Our customer service number is listed below.

Please call Tufts Health Plan Medicare Preferred for more information about Tufts Medicare Preferred HMO (HMO) plans.

Visit us at tuftsmedicarepreferred.org or, call us:

Customer Service Hours:
Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8:00 a.m. - 8:00 p.m. Eastern

Current members should call toll-free (800)-701-9000 for questions related to the Medicare Advantage Program and the Medicare Part D Prescription Drug program. (TTY/TDD (800)-208-9562)

Current members should call locally (800)-701-9000 for questions related to the Medicare Advantage Program and the Medicare Part D Prescription Drug program. (TTY/TDD (800)-208-9562)

Prospective members should call toll-free (800)-978-2222 for questions related to the Medicare Advantage Program and the Medicare Part D Prescription Drug program. (TTY/TDD (888)-899-8977)

Prospective members should call locally (800)-978-2222 for questions related to the Medicare Advantage Program and the Medicare Part D Prescription Drug program (TTY/TDD (888)-899-8977)

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, visit www.medicare.gov on the web.

This document may be available in other formats such as Braille, large print or other alternate formats.

This document may be available in a non-English language. For additional information, call customer service at the phone number listed above.

Este documento está disponible en otros idiomas aparte del inglés. Si desea información adicional, llame al servicio al cliente al número de teléfono que se indica arriba.

Tufts Medicare Preferred HMO (HMO) Plans Benefits Chart

Benefit Category	Original Medicare	Tufts Medicare Preferred HMO Basic (HMO)	Tufts Medicare Preferred HMO Basic Rx (HMO)	Tufts Medicare Preferred HMO Value (HMO)
Important Information				
1 - Premium & Other Important Information The premiums range from $0 – $184.40 therefore, please refer to the Premium Table located on **pages 88-89** after this section to find out what the premium is in your area.	In 2011 the monthly Part B Premium was $96.40 and may change for 2012 and the annual Part B deductible amount was $162 and may change for 2012. If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more. Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.	Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay a higher premium because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. **In-Network** $3,400 out-of-pocket limit for Medicare-covered services and select Non-Medicare Supplemental Services.	Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. **In-Network** $3,400 out-of-pocket limit for Medicare-covered services and select Non-Medicare Supplemental Services.	Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. **In-Network** $3,400 out-of-pocket limit for Medicare-covered services and select Non-Medicare Supplemental Services.

Tufts Medicare Preferred HMO Value Rx (HMO)	Tufts Medicare Preferred HMO Prime (HMO)	Tufts Medicare Preferred HMO Prime Rx (HMO)	Tufts Medicare Preferred HMO Prime Rx Plus (HMO)
Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.	Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.	Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.	Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.
In-Network $3,400 out-of-pocket limit for Medicare-covered services and select Non-Medicare Supplemental Services.	**In-Network** $3,400 out-of-pocket limit for Medicare-covered services and select Non-Medicare Supplemental Services.	**In-Network** $3,400 out-of-pocket limit for Medicare-covered services and select Non-Medicare Supplemental Services.	**In-Network** $3,400 out-of-pocket limit for Medicare-covered services and select Non-Medicare Supplemental Services.

Tufts Medicare Preferred HMO (HMO) Plans Benefits Chart

Benefit Category	Original Medicare	Tufts Medicare Preferred HMO Basic (HMO)	Tufts Medicare Preferred HMO Basic Rx (HMO)	Tufts Medicare Preferred HMO Value (HMO)
1 - Premium & Other Important Information cont.		Contact plan for details regarding Non-Medicare Supplemental Services covered under this limit.	Contact plan for details regarding Non-Medicare Supplemental Services covered under this limit.	Contact plan for details regarding Non-Medicare Supplemental Services covered under this limit.
2 - Doctor and Hospital Choice (For more information, see Emergency - #15 and Urgently Needed Care - #16) See page 95 for additional information about Referral Circles.	You may go to any doctor, specialist or hospital that accepts Medicare.	**In-Network** You must go to network doctors, specialists, and hospitals. Referral required for network specialists (for certain benefits).	**In-Network** You must go to network doctors, specialists, and hospitals. Referral required for network specialists (for certain benefits).	**In-Network** You must go to network doctors, specialists, and hospitals. Referral required for network specialists (for certain benefits).

Tufts Medicare Preferred HMO Value Rx (HMO)	Tufts Medicare Preferred HMO Prime (HMO)	Tufts Medicare Preferred HMO Prime Rx (HMO)	Tufts Medicare Preferred HMO Prime Rx Plus (HMO)
Contact plan for details regarding Non-Medicare Supplemental Services covered under this limit.	Contact plan for details regarding Non-Medicare Supplemental Services covered under this limit.	Contact plan for details regarding Non-Medicare Supplemental Services covered under this limit.	Contact plan for details regarding Non-Medicare Supplemental Services covered under this limit.
In-Network You must go to network doctors, specialists, and hospitals. Referral required for network specialists (for certain benefits).	**In-Network** You must go to network doctors, specialists, and hospitals. Referral required for network specialists (for certain benefits).	**In-Network** You must go to network doctors, specialists, and hospitals. Referral required for network specialists (for certain benefits).	**In-Network** You must go to network doctors, specialists, and hospitals. Referral required for network specialists (for certain benefits).

Tufts Medicare Preferred HMO (HMO) Plans Benefits Chart

Benefit Category	Original Medicare	Tufts Medicare Preferred HMO Basic (HMO)	Tufts Medicare Preferred HMO Basic Rx (HMO)	Tufts Medicare Preferred HMO Value (HMO)
Inpatient Care				
3 - Inpatient Hospital Care (Includes Substance Abuse and Rehabilitation Services) See page 92 for additional information about Inpatient Hospital Care.	In 2011 the amounts for each benefit period were: Days 1-60: $1132 deductible Days 61-90: $283 per day Days 91-150: $566 per lifetime reserve day These amounts may change for 2012. Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. Lifetime reserve days can only be used once. A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care.	**In-Network** No limit to the number of days covered by the plan each hospital stay. For Medicare-covered hospital stays: Days 1-10: $200 copay per day Days 11-90: $0 copay per day $0 copay for additional hospital days Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	**In-Network** No limit to the number of days covered by the plan each hospital stay. For Medicare-covered hospital stays: Days 1-10: $200 copay per day Days 11-90: $0 copay per day $0 copay for additional hospital days Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	**In-Network** No limit to the number of days covered by the plan each hospital stay. For Medicare-covered hospital stays: Days 1-5: $125 copay per day Days 6-90: $0 copay per day $0 copay for additional hospital days Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

Tufts Medicare Preferred HMO Value Rx (HMO)	Tufts Medicare Preferred HMO Prime (HMO)	Tufts Medicare Preferred HMO Prime Rx (HMO)	Tufts Medicare Preferred HMO Prime Rx Plus (HMO)
In-Network No limit to the number of days covered by the plan each hospital stay. For Medicare-covered hospital stays: Days 1-5: $125 copay per day Days 6-90: $0 copay per day $0 copay for additional hospital days Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	**In-Network** No limit to the number of days covered by the plan each hospital stay. $300 annual deductible $0 copay $300 out of pocket limit every year. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	**In-Network** No limit to the number of days covered by the plan each hospital stay. $300 annual deductible $0 copay $300 out of pocket limit every year. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	**In-Network** No limit to the number of days covered by the plan each hospital stay. $300 annual deductible $0 copay $300 out of pocket limit every year. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

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Benefit Category	Original Medicare	Tufts Medicare Preferred HMO Basic (HMO)	Tufts Medicare Preferred HMO Basic Rx (HMO)	Tufts Medicare Preferred HMO Value (HMO)
3 - Inpatient Hospital Care cont. (Includes Substance Abuse and Rehabilitation Services) See page 92 for additional information about Inpatient Hospital Care.	If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	See page 10	See page 10	See page 10

Tufts Medicare Preferred HMO Value Rx (HMO)	Tufts Medicare Preferred HMO Prime (HMO)	Tufts Medicare Preferred HMO Prime Rx (HMO)	Tufts Medicare Preferred HMO Prime Rx Plus (HMO)
See page 11	See page 11	See page 11	See page 11

Tufts Medicare Preferred HMO (HMO) Plans Benefits Chart

Benefit Category	Original Medicare	Tufts Medicare Preferred HMO Basic (HMO)	Tufts Medicare Preferred HMO Basic Rx (HMO)	Tufts Medicare Preferred HMO Value (HMO)
4 - Inpatient Mental Health Care See page 92 for additional information about Inpatient Mental Health Care.	In 2011 the amounts for each benefit period were: Days 1-60: $1132 deductible Days 61-90: $283 per day Days 91-150: $566 per lifetime reserve day These amounts may change for 2012. You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.	**In-Network** You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. For Medicare-covered hospital stays: Days 1-10: $179 copay per day Days 11-90: $0 copay per day Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	**In-Network** You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. For Medicare-covered hospital stays: Days 1-10: $179 copay per day Days 11-90: $0 copay per day Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	**In-Network** You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. For Medicare-covered hospital stays: Days 1-5: $125 copay per day Days 6-90: $0 copay per day Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

Tufts Medicare Preferred HMO Value Rx (HMO)	Tufts Medicare Preferred HMO Prime (HMO)	Tufts Medicare Preferred HMO Prime Rx (HMO)	Tufts Medicare Preferred HMO Prime Rx Plus (HMO)
In-Network You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. For Medicare-covered hospital stays: Days 1-5: $125 copay per day Days 6-90: $0 copay per day Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	**In-Network** $0 copay You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	**In-Network** $0 copay You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	**In-Network** $0 copay You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

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5 - Skilled Nursing Facility (SNF) (In a Medicare-certified skilled nursing facility)	In 2011 the amounts for each benefit period after at least a 3-day covered hospital stay were: Days 1-20: $0 per day Days 21-100: $141.50 per day These amounts may change for 2012. 100 days for each benefit period. A "benefit period" starts the day you go to a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	**General** Authorization rules may apply. **In-Network**: Plan covers up to 100 days each benefit period. No prior hospital stay is required. For SNF stays: Days 1-20: $65 copay per day Days 21-100: $0 copay per day	**General** Authorization rules may apply. **In-Network**: Plan covers up to 100 days each benefit period. No prior hospital stay is required. For SNF stays: Days 1-20: $65 copay per day Days 21-100: $0 copay per day	**General** Authorization rules may apply. **In-Network**: Plan covers up to 100 days each benefit period. No prior hospital stay is required. For SNF stays: Days 1-20: $35 copay per day Days 21-100: $0 copay per day

Tufts Medicare Preferred HMO Value Rx (HMO)	Tufts Medicare Preferred HMO Prime (HMO)	Tufts Medicare Preferred HMO Prime Rx (HMO)	Tufts Medicare Preferred HMO Prime Rx Plus (HMO)
General Authorization rules may apply. **In-Network**: Plan covers up to 100 days each benefit period. No prior hospital stay is required. For SNF stays: Days 1-20: $35 copay per day Days 21-100: $0 copay per day	**General** Authorization rules may apply. **In-Network** Plan covers up to 100 days each benefit period. No prior hospital stay is required. $0 copay for SNF services	**General** Authorization rules may apply. **In-Network** Plan covers up to 100 days each benefit period. No prior hospital stay is required. $0 copay for SNF services	**General** Authorization rules may apply. **In-Network** Plan covers up to 100 days each benefit period. No prior hospital stay is required. $0 copay for SNF services

Benefit Category	Original Medicare	Tufts Medicare Preferred HMO Basic (HMO)	Tufts Medicare Preferred HMO Basic Rx (HMO)	Tufts Medicare Preferred HMO Value (HMO)
6 - Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	$0 copay	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered home health visits.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered home health visits.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered home health visits.
7 - Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice.	**General** You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.	**General** You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.	**General** You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.

Tufts Medicare Preferred HMO Value Rx (HMO)	Tufts Medicare Preferred HMO Prime (HMO)	Tufts Medicare Preferred HMO Prime Rx (HMO)	Tufts Medicare Preferred HMO Prime Rx Plus (HMO)
General Authorization rules may apply. **In-Network** $0 copay for Medicare-covered home health visits.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered home health visits.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered home health visits.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered home health visits.
General You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.	**General** You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.	**General** You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.	**General** You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.

Tufts Medicare Preferred HMO (HMO) Plans Benefits Chart

Benefit Category	Original Medicare	Tufts Medicare Preferred HMO Basic (HMO)	Tufts Medicare Preferred HMO Basic Rx (HMO)	Tufts Medicare Preferred HMO Value (HMO)
Outpatient Care				
8 - Doctor Office Visits	20% coinsurance	**In-Network** $20 copay for each primary care doctor visit for Medicare-covered benefits. $20 to $30 copay for each in-area network urgent care Medicare-covered visit. $30 copay for each specialist visit for Medicare-covered benefits.	**In-Network** $20 copay for each primary care doctor visit for Medicare-covered benefits. $20 to $30 copay for each in-area network urgent care Medicare-covered visit. $30 copay for each specialist visit for Medicare-covered benefits.	**In-Network** $15 copay for each primary care doctor visit for Medicare-covered benefits. $15 to $20 copay for each in-area network urgent care Medicare-covered visit. $20 copay for each specialist visit for Medicare-covered benefits.
9 - Chiropractic Services	Supplemental routine care not covered. 20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.	**In-Network** $15 copay for each Medicare-covered visit. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displace-ment or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.	**In-Network** $15 copay for each Medicare-covered visit. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displace-ment or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.	**In-Network** $15 copay for each Medicare-covered visit. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displace-ment or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.

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Tufts Medicare Preferred HMO Value Rx (HMO)	Tufts Medicare Preferred HMO Prime (HMO)	Tufts Medicare Preferred HMO Prime Rx (HMO)	Tufts Medicare Preferred HMO Prime Rx Plus (HMO)
In-Network $15 copay for each primary care doctor visit for Medicare-covered benefits. $15 to $20 copay for each in-area network urgent care Medicare-covered visit. $20 copay for each specialist visit for Medicare-covered benefits.	**In-Network** $10 copay for each primary care doctor visit for Medicare-covered benefits. $10 to $15 copay for each in-area network urgent care Medicare-covered visit. $15 copay for each specialist visit for Medicare-covered benefits.	**In-Network** $10 copay for each primary care doctor visit for Medicare-covered benefits. $10 to $15 copay for each in-area network urgent care Medicare-covered visit. $15 copay for each specialist visit for Medicare-covered benefits.	**In-Network** $10 copay for each primary care doctor visit for Medicare-covered benefits. $10 to $15 copay for each in-area network urgent care Medicare-covered visit. $15 copay for each specialist visit for Medicare-covered benefits.
In-Network $15 copay for each Medicare-covered visit. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.	**In-Network** $15 copay for each Medicare-covered visit. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.	**In-Network** $15 copay for each Medicare-covered visit. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.	**In-Network** $15 copay for each Medicare-covered visit. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.

Tufts Medicare Preferred HMO (HMO) Plans Benefits Chart

Benefit Category	Original Medicare	Tufts Medicare Preferred HMO Basic (HMO)	Tufts Medicare Preferred HMO Basic Rx (HMO)	Tufts Medicare Preferred HMO Value (HMO)
10 - Podiatry Services	Supplemental routine care not covered. 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	**In-Network** $30 copay for each Medicare-covered visit. Medicare covered podiatry benefits are for medically-necessary foot care.	**In-Network** $30 copay for each Medicare-covered visit. Medicare covered podiatry benefits are for medically-necessary foot care.	**In-Network** $20 copay for each Medicare-covered visit. Medicare covered podiatry benefits are for medically-necessary foot care.

Tufts Medicare Preferred HMO Value Rx (HMO)	Tufts Medicare Preferred HMO Prime (HMO)	Tufts Medicare Preferred HMO Prime Rx (HMO)	Tufts Medicare Preferred HMO Prime Rx Plus (HMO)
In-Network $20 copay for each Medicare-covered visit. Medicare covered podiatry benefits are for medically-necessary foot care.	**In-Network** $15 copay for each Medicare-covered visit. Medicare covered podiatry benefits are for medically-necessary foot care.	**In-Network** $15 copay for each Medicare-covered visit. Medicare covered podiatry benefits are for medically-necessary foot care.	**In-Network** $15 copay for each Medicare-covered visit. Medicare covered podiatry benefits are for medically-necessary foot care.

Tufts Medicare Preferred HMO (HMO) Plans Benefits Chart

Benefit Category	Original Medicare	Tufts Medicare Preferred HMO Basic (HMO)	Tufts Medicare Preferred HMO Basic Rx (HMO)	Tufts Medicare Preferred HMO Value (HMO)
11 - Outpatient Mental Health Care	40% coinsurance for most outpatient mental health services. Specified copayment for outpatient partial hospitalization program services furnished by a hospital or community mental health center (CMHC). Copay cannot exceed the Part A inpatient hospital deductible. "Partial hospitalization program" is a structured program of active outpatient psychiatric treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	**General** Authorization rules may apply. **In-Network** $30 copay for each Medicare-covered individual therapy visit. $30 copay for each Medicare-covered group therapy visit $30 copay for each Medicare-covered individual therapy visit with a psychiatrist $30 copay for each Medicare-covered group therapy visit with a psychiatrist $0 copay for Medicare-covered partial hospitalization program services	**General** Authorization rules may apply. **In-Network** $30 copay for each Medicare-covered individual therapy visit. $30 copay for each Medicare-covered group therapy visit $30 copay for each Medicare-covered individual therapy visit with a psychiatrist $30 copay for each Medicare-covered group therapy visit with a psychiatrist $0 copay for Medicare-covered partial hospitalization program services	**General** Authorization rules may apply. **In-Network** $20 copay for each Medicare-covered individual therapy visit. $20 copay for each Medicare-covered group therapy visit $20 copay for each Medicare-covered individual therapy visit with a psychiatrist $20 copay for each Medicare-covered group therapy visit with a psychiatrist $0 copay for Medicare-covered partial hospitalization program services

Tufts Medicare Preferred HMO Value Rx (HMO)	Tufts Medicare Preferred HMO Prime (HMO)	Tufts Medicare Preferred HMO Prime Rx (HMO)	Tufts Medicare Preferred HMO Prime Rx Plus (HMO)
General Authorization rules may apply. **In-Network** $20 copay for each Medicare-covered individual therapy visit. $20 copay for each Medicare-covered group therapy visit $20 copay for each Medicare-covered individual therapy visit with a psychiatrist $20 copay for each Medicare-covered group therapy visit with a psychiatrist $0 copay for Medicare-covered partial hospitalization program services	**General** Authorization rules may apply. **In-Network** $15 copay for each Medicare-covered individual therapy visit. $15 copay for each Medicare-covered group therapy visit $15 copay for each Medicare-covered individual therapy visit with a psychiatrist $15 copay for each Medicare-covered group therapy visit with a psychiatrist $0 copay for Medicare-covered partial hospitalization program services	**General** Authorization rules may apply. **In-Network** $15 copay for each Medicare-covered individual therapy visit. $15 copay for each Medicare-covered group therapy visit $15 copay for each Medicare-covered individual therapy visit with a psychiatrist $15 copay for each Medicare-covered group therapy visit with a psychiatrist $0 copay for Medicare-covered partial hospitalization program services	**General** Authorization rules may apply. **In-Network** $15 copay for each Medicare-covered individual therapy visit. $15 copay for each Medicare-covered group therapy visit $15 copay for each Medicare-covered individual therapy visit with a psychiatrist $15 copay for each Medicare-covered group therapy visit with a psychiatrist $0 copay for Medicare-covered partial hospitalization program services

Tufts Medicare Preferred HMO (HMO) Plans Benefits Chart

Benefit Category	Original Medicare	Tufts Medicare Preferred HMO Basic (HMO)	Tufts Medicare Preferred HMO Basic Rx (HMO)	Tufts Medicare Preferred HMO Value (HMO)
12 - Outpatient Substance Abuse Care	20% coinsurance	**In-Network** $30 copay for Medicare-covered individual visits. $30 copay for Medicare-covered group visits	**In-Network** $30 copay for Medicare-covered individual visits. $30 copay for Medicare-covered group visits	**In-Network** $20 copay for Medicare-covered individual visits. $20 copay for Medicare-covered group visits
13 - Outpatient Services / Surgery	20% coinsurance for the doctor's services Specified copayment for outpatient hospital facility services. Copay cannot exceed the Part A inpatient hospital deductible. 20% copayment for ambulatory surgical center facility services.	**General** Authorization rules may apply. **In-Network** $165 copay for each Medicare-covered ambulatory surgical center visit. $165 copay for each Medicare-covered outpatient hospital facility visit.	**General** Authorization rules may apply. **In-Network** $165 copay for each Medicare-covered ambulatory surgical center visit. $165 copay for each Medicare-covered outpatient hospital facility visit.	**General** Authorization rules may apply. **In-Network** $150 copay for each Medicare-covered ambulatory surgical center visit. $150 copay for each Medicare-covered outpatient hospital facility visit.

Tufts Medicare Preferred HMO Value Rx (HMO)	Tufts Medicare Preferred HMO Prime (HMO)	Tufts Medicare Preferred HMO Prime Rx (HMO)	Tufts Medicare Preferred HMO Prime Rx Plus (HMO)
In-Network $20 copay for Medicare-covered individual visits. $20 copay for Medicare-covered group visits	**In-Network** $15 copay for Medicare-covered individua visits. $15 copay for Medicare-covered group visits	**In-Network** $15 copay for Medicare-covered individual visits. $15 copay for Medicare-covered group visits	**In-Network** $15 copay for Medicare-covered individual visits. $15 copay for Medicare-covered group visits
General Authorization rules may apply. **In-Network** $150 copay for each Medicare-covered ambulatory surgical center visit. $150 copay for each Medicare-covered outpatient hospital facility visit.	**General** Authorization rules may apply. **In-Network** $50 copay for each Medicare-covered ambulatory surgical center visit. $50 copay for each Medicare-covered outpatient hospital facility visit.	**General** Authorization rules may apply. **In-Network** $50 copay for each Medicare-covered ambulatory surgical center visit. $50 copay for each Medicare-covered outpatient hospital facility visit.	**General** Authorization rules may apply. **In-Network** $50 copay for each Medicare-covered ambulatory surgical center visit. $50 copay for each Medicare-covered outpatient hospital facility visit.

Benefit Category	Original Medicare	Tufts Medicare Preferred HMO Basic (HMO)	Tufts Medicare Preferred HMO Basic Rx (HMO)	Tufts Medicare Preferred HMO Value (HMO)
14 - Ambulance Services (medically necessary ambulance services) See page 92 for additional information about Ambulance Services.	20% coinsurance	**In-Network** $150 copay for Medicare-covered ambulance benefits.	**In-Network** $150 copay for Medicare-covered ambulance benefits.	**In-Network** $100 copay for Medicare-covered ambulance benefits.
15 - Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.) See page 92 for additional information about Emergency Care.	20% coinsurance for the doctor's services Specified copayment for outpatient hospital facility services. Emergency services copay cannot exceed Part A inpatient hospital deductible for each service provided by the hospital. You don't have to pay the emergency room copay if you are admitted to the hospital as an inpatient for the same condition within 3 days of the emergency room visit. NOT covered outside the U.S. except under limited circumstances.	**General** $65 copay for Medicare-covered emergency room visits. Worldwide coverage. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay $0 for the emergency room visit.	**General** $65 copay for Medicare-covered emergency room visits. Worldwide coverage. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay $0 for the emergency room visit.	**General** $65 copay for Medicare-covered emergency room visits. Worldwide coverage. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay $0 for the emergency room visit.

Tufts Medicare Preferred HMO Value Rx (HMO)	Tufts Medicare Preferred HMO Prime (HMO)	Tufts Medicare Preferred HMO Prime Rx (HMO)	Tufts Medicare Preferred HMO Prime Rx Plus (HMO)
In-Network $100 copay for Medicare-covered ambulance benefits.	**In-Network** $50 copay for Medicare-covered ambulance benefits.	**In-Network** $50 copay for Medicare-covered ambulance benefits.	**In-Network** $50 copay for Medicare-covered ambulance benefits.
General $65 copay for Medicare-covered emergency room visits. Worldwide coverage. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay $0 for the emergency room visit.	**General** $65 copay for Medicare-covered emergency room visits. Worldwide coverage. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay $0 for the emergency room visit.	**General** $65 copay for Medicare-covered emergency room visits. Worldwide coverage. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay $0 for the emergency room visit.	**General** $65 copay for Medicare-covered emergency room visits. Worldwide coverage. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay $0 for the emergency room visit.

Benefit Category	Original Medicare	Tufts Medicare Preferred HMO Basic (HMO)	Tufts Medicare Preferred HMO Basic Rx (HMO)	Tufts Medicare Preferred HMO Value (HMO)
16 - Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.) See page 92 for additional information about Urgently Needed Care.	20% coinsurance, or a set copay NOT covered outside the U.S. except under limited circumstances.	**General** $20 to $30 copay for Medicare-covered urgently-needed-care visits.	**General** $20 to $30 copay for Medicare-covered urgently-needed-care visits.	**General** $15 to $20 copay for Medicare-covered urgently-needed-care visits.
17 - Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	20% coinsurance	**In-Network** $30 copay for Medicare-covered Occupational Therapy visits. $30 copay for Medicare-covered Physical and/or Speech and Language Therapy visits.	**In-Network** $30 copay for Medicare-covered Occupational Therapy visits. $30 copay for Medicare-covered Physical and/or Speech and Language Therapy visits.	**In-Network** $20 copay for Medicare-covered Occupational Therapy visits. $20 copay for Medicare-covered Physical and/or Speech and Language Therapy visits.

Tufts Medicare Preferred HMO Value Rx (HMO)	Tufts Medicare Preferred HMO Prime (HMO)	Tufts Medicare Preferred HMO Prime Rx (HMO)	Tufts Medicare Preferred HMO Prime Rx Plus (HMO)
General $15 to $20 copay for Medicare-covered urgently-needed-care visits.	**General** $10 to $15 copay for Medicare-covered urgently-needed-care visits.	**General** $10 to $15 copay for Medicare-covered urgently-needed-care visits.	**General** $10 to $15 copay for Medicare-covered urgently-needed-care visits.
In-Network $20 copay for Medicare-covered Occupational Therapy visits. $20 copay for Medicare-covered Physical and/or Speech and Language Therapy visits.	**In-Network** $15 copay for Medicare-covered Occupational Therapy visits. $15 copay for Medicare-covered Physical and/or Speech and Language Therapy visits.	**In-Network** $15 copay for Medicare-covered Occupational Therapy visits. $15 copay for Medicare-covered Physical and/or Speech and Language Therapy visits.	**In-Network** $15 copay for Medicare-covered Occupational Therapy visits. $15 copay for Medicare-covered Physical and/or Speech and Language Therapy visits.

Benefit Category	Original Medicare	Tufts Medicare Preferred HMO Basic (HMO)	Tufts Medicare Preferred HMO Basic Rx (HMO)	Tufts Medicare Preferred HMO Value (HMO)
Outpatient Medical Services and Supplies				
18 - Durable Medical Equipment (includes wheelchairs, oxygen, etc.) See page 91 for additional information about Durable Medical Equipment.	20% coinsurance	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered items.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered items.	**General** Authorization rules may apply. **In-Network** 10% of the cost for Medicare-covered items.
19 - Prosthetic Devices (includes braces, artificial limbs and eyes, etc.) See page 91 for additional information about Prosthetics.	20% coinsurance	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered items.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered items.	**General** Authorization rules may apply. **In-Network** 10% of the cost for Medicare-covered items.

Tufts Medicare Preferred HMO Value Rx (HMO)	Tufts Medicare Preferred HMO Prime (HMO)	Tufts Medicare Preferred HMO Prime Rx (HMO)	Tufts Medicare Preferred HMO Prime Rx Plus (HMO)
General Authorization rules may apply. **In-Network** 10% of the cost for Medicare-covered items.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered items.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered items.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered items.
General Authorization rules may apply. **In-Network** 10% of the cost for Medicare-covered items.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered items.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered items.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered items.

Benefit Category	Original Medicare	Tufts Medicare Preferred HMO Basic (HMO)	Tufts Medicare Preferred HMO Basic Rx (HMO)	Tufts Medicare Preferred HMO Value (HMO)
20 - Diabetes Programs and Supplies	20% coinsurance for diabetes self-management training 20% coinsurance for diabetes supplies 20% coinsurance for diabetic therapeutic shoes or inserts	**General** Authorization rules may apply. **In-Network** $0 copay for Diabetes self-management training. $0 copay for: • Diabetes monitoring supplies • Therapeutic shoes or inserts If the doctor provides you services in addition to Diabetes self-management training, separate cost sharing of $20 to $30 may apply	**General** Authorization rules may apply. **In-Network** $0 copay for Diabetes self-management training. $0 copay for: • Diabetes monitoring supplies • Therapeutic shoes or inserts If the doctor provides you services in addition to Diabetes self-management training, separate cost sharing of $20 to $30 may apply	**General** Authorization rules may apply. **In-Network** $0 copay for Diabetes self-management training. $0 copay for: • Diabetes monitoring supplies • Therapeutic shoes or inserts If the doctor provides you services in addition to Diabetes self-management training, separate cost sharing of $15 to $20 may apply

Tufts Medicare Preferred HMO Value Rx (HMO)	Tufts Medicare Preferred HMO Prime (HMO)	Tufts Medicare Preferred HMO Prime Rx (HMO)	Tufts Medicare Preferred HMO Prime Rx Plus (HMO)
General Authorization rules may apply. **In-Network** $0 copay for Diabetes self-management training. $0 copay for: • Diabetes monitoring supplies • Therapeutic shoes or inserts If the doctor provides you services in addition to Diabetes self-management training, separate cost sharing of $15 to $20 may apply	**General** Authorization rules may apply. **In-Network** $0 copay for Diabetes self-management training. $0 copay for: • Diabetes monitoring supplies • Therapeutic shoes or inserts If the doctor provides you services in addition to Diabetes self-management training, separate cost sharing of $10 to $15 may apply	**General** Authorization rules may apply. **In-Network** $0 copay for Diabetes self-management training. $0 copay for: • Diabetes monitoring supplies • Therapeutic shoes or inserts If the doctor provides you services in addition to Diabetes self-management training, separate cost sharing of $10 to $15 may apply	**General** Authorization rules may apply. **In-Network** $0 copay for Diabetes self-management training. $0 copay for: • Diabetes monitoring supplies • Therapeutic shoes or inserts If the doctor provides you services in addition to Diabetes self-management training, separate cost sharing of $10 to $15 may apply

Tufts Medicare Preferred HMO (HMO) Plans Benefits Chart

Benefit Category	Original Medicare	Tufts Medicare Preferred HMO Basic (HMO)	Tufts Medicare Preferred HMO Basic Rx (HMO)	Tufts Medicare Preferred HMO Value (HMO)
21 - Diagnostic Tests, X-Rays, Lab Services and Radiology Services	20% coinsurance for diagnostic tests and X-rays. $0 copay for Medicare covered lab services. Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most supplemental routine screening tests, like checking your cholesterol. 20% coinsurance for digital rectal exam and other related services. Covered once a year for all men with Medicare over age 50.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered: • lab services • diagnostic procedures and tests $1 to $100 copay for Medicare-covered X-rays. $1 to $100 copay for Medicare-covered diagnostic radiology services (not including X-rays). $0 copay for Medicare-covered therapeutic radiology services.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered: • lab services • diagnostic procedures and tests $1 to $100 copay for Medicare-covered X-rays. $1 to $100 copay for Medicare-covered diagnostic radiology services (not including X-rays). $0 copay for Medicare-covered therapeutic radiology services.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered: • lab services • diagnostic procedures and tests $1 to $100 copay for Medicare-covered X-rays. $1 to $100 copay for Medicare-covered diagnostic radiology services (not including X-rays). $0 copay for Medicare-covered therapeutic radiology services.

Tufts Medicare Preferred HMO Value Rx (HMO)	Tufts Medicare Preferred HMO Prime (HMO)	Tufts Medicare Preferred HMO Prime Rx (HMO)	Tufts Medicare Preferred HMO Prime Rx Plus (HMO)
General Authorization rules may apply. **In-Network** $0 copay for Medicare-covered: • lab services • diagnostic procedures and tests $1 to $100 copay for Medicare-covered X-rays. $1 to $100 copay for Medicare-covered diagnostic radiology services (not including X-rays). $0 copay for Medicare-covered therapeutic radiology services.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered: • lab services • diagnostic procedures and tests • X-rays • diagnostic radiology services (not including X-rays) • therapeutic radiology services	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered: • lab services • diagnostic procedures and tests • X-rays • diagnostic radiology services (not including X-rays) • therapeutic radiology services	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered: • lab services • diagnostic procedures and tests • X-rays • diagnostic radiology services (not including X-rays) • therapeutic radiology services

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Benefit Category	Original Medicare	Tufts Medicare Preferred HMO Basic (HMO)	Tufts Medicare Preferred HMO Basic Rx (HMO)	Tufts Medicare Preferred HMO Value (HMO)
22 - Cardiac and Pulmonary Rehabilitation Services	20% coinsurance for Cardiac Rehabilitation services 20% coinsurance for Pulmonary Rehabilitation services 20% coinsurance for Intensive Cardiac Rehabilitation services This applies to program services provided in a doctors office. Specified cost sharing for program services provided by hospital outpatient departments.	**General** Authorization rules may apply. **In-Network** $0 copay for: • Medicare-covered Cardiac Rehabilitation Services • Medicare-covered Intensive Cardiac Rehabilitation Services • Medicare-covered Pulmonary Rehabilitation Services	**General** Authorization rules may apply. **In-Network** $0 copay for: • Medicare-covered Cardiac Rehabilitation Services • Medicare-covered Intensive Cardiac Rehabilitation Services • Medicare-covered Pulmonary Rehabilitation Services	**General** Authorization rules may apply. **In-Network** $0 copay for: • Medicare-covered Cardiac Rehabilitation Services • Medicare-covered Intensive Cardiac Rehabilitation Services • Medicare-covered Pulmonary Rehabilitation Services

Tufts Medicare Preferred HMO Value Rx (HMO)	Tufts Medicare Preferred HMO Prime (HMO)	Tufts Medicare Preferred HMO Prime Rx (HMO)	Tufts Medicare Preferred HMO Prime Rx Plus (HMO)
General Authorization rules may apply. **In-Network** $0 copay for: • Medicare-covered Cardiac Rehabilitation Services • Medicare-covered Intensive Cardiac Rehabilitation Services • Medicare-covered Pulmonary Rehabilitation Services	**General** Authorization rules may apply. **In-Network** $0 copay for: • Medicare-covered Cardiac Rehabilitation Services • Medicare-covered Intensive Cardiac Rehabilitation Services • Medicare-covered Pulmonary Rehabilitation Services	**General** Authorization rules may apply. **In-Network** $0 copay for: • Medicare-covered Cardiac Rehabilitation Services • Medicare-covered Intensive Cardiac Rehabilitation Services • Medicare-covered Pulmonary Rehabilitation Services	**General** Authorization rules may apply. **In-Network** $0 copay for: • Medicare-covered Cardiac Rehabilitation Services • Medicare-covered Intensive Cardiac Rehabilitation Services • Medicare-covered Pulmonary Rehabilitation Services

Tufts Medicare Preferred HMO (HMO) Plans Benefits Chart

Benefit Category	Original Medicare	Tufts Medicare Preferred HMO Basic (HMO)	Tufts Medicare Preferred HMO Basic Rx (HMO)	Tufts Medicare Preferred HMO Value (HMO)
Preventive Services				
23 - Preventive Services and Wellness/Education Programs	No coinsurance, copayment or deductible for the following: • Abdominal Aortic Aneurysm Screening • Bone Mass Measurement. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions. • Cardiovascular Screening • Cervical and Vaginal Cancer Screening. Covered once every 2 years. Covered once a year for women with Medicare at high risk. • Colorectal Cancer Screening • Diabetes Screening • Influenza Vaccine • Hepatitis B Vaccine for people with Medicare who are at risk	**General** $0 copay for all preventive services covered under Original Medicare at zero cost sharing: • Abdominal Aortic Aneurysm Screening • Bone Mass Measurement • Cardiovascular Screening • Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) • Colorectal Cancer Screening • Diabetes Screening • Influenza Vaccine • Hepatitis B Vaccine • HIV Screening • Breast Cancer Screening (Mammogram) • Medical Nutrition Therapy Services	**General** $0 copay for all preventive services covered under Original Medicare at zero cost sharing: • Abdominal Aortic Aneurysm Screening • Bone Mass Measurement • Cardiovascular Screening • Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) • Colorectal Cancer Screening • Diabetes Screening • Influenza Vaccine • Hepatitis B Vaccine • HIV Screening • Breast Cancer Screening (Mammogram) • Medical Nutrition Therapy Services	**General** $0 copay for all preventive services covered under Original Medicare at zero cost sharing: • Abdominal Aortic Aneurysm Screening • Bone Mass Measurement • Cardiovascular Screening • Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) • Colorectal Cancer Screening • Diabetes Screening • Influenza Vaccine • Hepatitis B Vaccine • HIV Screening • Breast Cancer Screening (Mammogram) • Medical Nutrition Therapy Services

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Tufts Medicare Preferred HMO Value Rx (HMO)	Tufts Medicare Preferred HMO Prime (HMO)	Tufts Medicare Preferred HMO Prime Rx (HMO)	Tufts Medicare Preferred HMO Prime Rx Plus (HMO)
General $0 copay for all preventive services covered under Original Medicare at zero cost sharing: • Abdominal Aortic Aneurysm Screening • Bone Mass Measurement • Cardiovascular Screening • Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) • Colorectal Cancer Screening • Diabetes Screening • Influenza Vaccine • Hepatitis B Vaccine • HIV Screening • Breast Cancer Screening (Mammogram) • Medical Nutrition Therapy Services	**General** $0 copay for all preventive services covered under Original Medicare at zero cost sharing: • Abdominal Aortic Aneurysm Screening • Bone Mass Measurement • Cardiovascular Screening • Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) • Colorectal Cancer Screening • Diabetes Screening • Influenza Vaccine • Hepatitis B Vaccine • HIV Screening • Breast Cancer Screening (Mammogram) • Medical Nutrition Therapy Services	**General** $0 copay for all preventive services covered under Original Medicare at zero cost sharing: • Abdominal Aortic Aneurysm Screening • Bone Mass Measurement • Cardiovascular Screening • Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) • Colorectal Cancer Screening • Diabetes Screening • Influenza Vaccine • Hepatitis B Vaccine • HIV Screening • Breast Cancer Screening (Mammogram) • Medical Nutrition Therapy Services	**General** $0 copay for all preventive services covered under Original Medicare at zero cost sharing: • Abdominal Aortic Aneurysm Screening • Bone Mass Measurement • Cardiovascular Screening • Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) • Colorectal Cancer Screening • Diabetes Screening • Influenza Vaccine • Hepatitis B Vaccine • HIV Screening • Breast Cancer Screening (Mammogram) • Medical Nutrition Therapy Services

Tufts Medicare Preferred HMO (HMO) Plans Benefits Chart

Benefit Category	Original Medicare	Tufts Medicare Preferred HMO Basic (HMO)	Tufts Medicare Preferred HMO Basic Rx (HMO)	Tufts Medicare Preferred HMO Value (HMO)
23 - Preventive Services and Wellness/Education Programs cont.	• HIV Screening. $0 copay for the HIV screening, but you generally pay 20% of the Medicare-approved amount for the doctor's visit. HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. • Breast Cancer Screening (Mammogram). Medicare covers screening mammograms once every 12 months for all women with	• Personalized Prevention Plan (Annual Wellness Visits) • Pneumococcal Vaccine • Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only) • Smoking Cessation (Counseling to stop smoking) • Welcome to Medicare Physical Exam (Initial Preventive Physical Exam) HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test.	• Personalized Prevention Plan (Annual Wellness Visits) • Pneumococcal Vaccine • Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only) • Smoking Cessation (Counseling to stop smoking) • Welcome to Medicare Physical Exam (Initial Preventive Physical Exam) HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test.	• Personalized Prevention Plan (Annual Wellness Visits) • Pneumococcal Vaccine • Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only) • Smoking Cessation (Counseling to stop smoking) • Welcome to Medicare Physical Exam (Initial Preventive Physical Exam) HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test.

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Tufts Medicare Preferred HMO Value Rx (HMO)	Tufts Medicare Preferred HMO Prime (HMO)	Tufts Medicare Preferred HMO Prime Rx (HMO)	Tufts Medicare Preferred HMO Prime Rx Plus (HMO)
• Personalized Prevention Plan (Annual Wellness Visits) • Pneumococcal Vaccine • Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only) • Smoking Cessation (Counseling to stop smoking) • Welcome to Medicare Physical Exam (Initial Preventive Physical Exam) HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test.	• Personalized Prevention Plan (Annual Wellness Visits) • Pneumococcal Vaccine • Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only) • Smoking Cessation (Counseling to stop smoking) • Welcome to Medicare Physical Exam (Initial Preventive Physical Exam) HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test.	• Personalized Prevention Plan (Annual Wellness Visits) • Pneumococcal Vaccine • Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only) • Smoking Cessation (Counseling to stop smoking) • Welcome to Medicare Physical Exam (Initial Preventive Physical Exam) HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test.	• Personalized Prevention Plan (Annual Wellness Visits) • Pneumococcal Vaccine • Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only) • Smoking Cessation (Counseling to stop smoking) • Welcome to Medicare Physical Exam (Initial Preventive Physical Exam) HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test.

Tufts Medicare Preferred HMO (HMO) Plans Benefits Chart

Benefit Category	Original Medicare	Tufts Medicare Preferred HMO Basic (HMO)	Tufts Medicare Preferred HMO Basic Rx (HMO)	Tufts Medicare Preferred HMO Value (HMO)
23 - Preventive Services and Wellness/Education Programs cont.	Medicare age 40 and older. Medicare covers one baseline mammogram for women between ages 35-39. • Medical Nutrition Therapy Services. Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian and may include a nutritional assessment and counseling to help you manage your diabetes or kidney disease. • Personalized Prevention Plan (Annual Wellness Visits)	Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details. **In-Network** $0 copay for: • Up to 1 additional pap smear(s) every year The plan covers the following supplemental education/wellness programs: • Written health education materials, including Newsletters • Nutritional benefit • Health Club Membership/Fitness Classes	Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details. **In-Network** $0 copay for: • Up to 1 additional pap smear(s) every year The plan covers the following supplemental education/wellness programs: • Written health education materials, including Newsletters • Nutritional benefit • Health Club Membership/Fitness Classes	Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details. **In-Network** $0 copay for: • Up to 1 additional pap smear(s) every year The plan covers the following supplemental education/wellness programs: • Written health education materials, including Newsletters • Nutritional benefit • Health Club Membership/Fitness Classes

Tufts Medicare Preferred HMO Value Rx (HMO)	Tufts Medicare Preferred HMO Prime (HMO)	Tufts Medicare Preferred HMO Prime Rx (HMO)	Tufts Medicare Preferred HMO Prime Rx Plus (HMO)
Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details. **In-Network** $0 copay for: • Up to 1 additional pap smear(s) every year The plan covers the following supplemental education/wellness programs: • Written health education materials, including Newsletters • Nutritional benefit • Health Club Membership/Fitness Classes	Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details. **In-Network** $0 copay for: • Up to 1 additional pap smear(s) every year The plan covers the following supplemental education/wellness programs: • Written health education materials, including Newsletters • Nutritional benefit • Health Club Membership/Fitness Classes	Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details. **In-Network** $0 copay for: • Up to 1 additional pap smear(s) every year The plan covers the following supplemental education/wellness programs: • Written health education materials, including Newsletters • Nutritional benefit • Health Club Membership/Fitness Classes	Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details. **In-Network** $0 copay for: • Up to 1 additional pap smear(s) every year The plan covers the following supplemental education/wellness programs: • Written health education materials, including Newsletters • Nutritional benefit • Health Club Membership/Fitness Classes

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Benefit Category	Original Medicare	Tufts Medicare Preferred HMO Basic (HMO)	Tufts Medicare Preferred HMO Basic Rx (HMO)	Tufts Medicare Preferred HMO Value (HMO)
23 - Preventive Services and Wellness/Education Programs cont.	• Pneumococcal Vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information. • Prostate Cancer Screening–Prostate Specific Antigen (PSA) test only. Covered once a year for all men with Medicare over age 50. • Smoking Cessation (counseling to stop smoking). Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits. • Welcome to Medicare Physical Exam (initial preventive physical	See page 40-44	See page 40-44	See page 40-44

Tufts Medicare Preferred HMO Value Rx (HMO)	Tufts Medicare Preferred HMO Prime (HMO)	Tufts Medicare Preferred HMO Prime Rx (HMO)	Tufts Medicare Preferred HMO Prime Rx Plus (HMO)
See page 41-45	See page 41-45	See page 41-45	See page 41-45

Benefit Category	Original Medicare	Tufts Medicare Preferred HMO Basic (HMO)	Tufts Medicare Preferred HMO Basic Rx (HMO)	Tufts Medicare Preferred HMO Value (HMO)
23 - Preventive Services and Wellness/Education Programs cont.	exam) When you join Medicare Part B, then you are eligible as follows. During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare Physical Exam or an Annual Wellness Visit. After your first 12 months, you can get one Annual Wellness Visit every 12 months.	See page 40-44	See page 40-44	See page 40-44
24 - Kidney Disease and Conditions	20% coinsurance for renal dialysis 20% coinsurance for kidney disease education services	**In-Network** $0 copay for renal dialysis $0 copay for kidney disease education services	**In-Network** $0 copay for renal dialysis $0 copay for kidney disease education services	**In-Network** $0 copay for renal dialysis $0 copay for kidney disease education services

Tufts Medicare Preferred HMO Value Rx (HMO)	Tufts Medicare Preferred HMO Prime (HMO)	Tufts Medicare Preferred HMO Prime Rx (HMO)	Tufts Medicare Preferred HMO Prime Rx Plus (HMO)
See page 41-45	See page 41-45	See page 41-45	See page 41-45
In-Network $0 copay for renal dialysis $0 copay for kidney disease education services	**In-Network** $0 copay for renal dialysis $0 copay for kidney disease education services	**In-Network** $0 copay for renal dialysis $0 copay for kidney disease education services	**In-Network** $0 copay for renal dialysis $0 copay for kidney disease education services

Benefit Category	Original Medicare	Tufts Medicare Preferred HMO Basic (HMO)	Tufts Medicare Preferred HMO Basic Rx (HMO)	Tufts Medicare Preferred HMO Value (HMO)
25 - Outpatient Prescription Drugs	Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.	**Drugs Covered Under Medicare Part B** **General** Most drugs not covered $0 copay for Part B-covered drugs.	**Drugs Covered Under Medicare Part B** **General** $0 copay for Part B-covered drugs. **Home Infusion Drugs, Supplies and Services** **General** $0 copay for home infusion drugs that would normally be covered under Part D. This cost-sharing amount will also cover the supplies and services associated with home infusion of these drugs.	**Drugs Covered Under Medicare Part B** **General** Most drugs not covered $0 copay for Part B-covered drugs.

Tufts Medicare Preferred HMO Value Rx (HMO)	Tufts Medicare Preferred HMO Prime (HMO)	Tufts Medicare Preferred HMO Prime Rx (HMO)	Tufts Medicare Preferred HMO Prime Rx Plus (HMO)
Drugs Covered Under Medicare Part B **General** $0 copay for Part B-covered drugs. **Home Infusion Drugs, Supplies and Services** **General** $0 copay for home infusion drugs that would normally be covered under Part D. This cost-sharing amount will also cover the supplies and services associated with home infusion of these drugs.	**Drugs Covered Under Medicare Part B** **General** Most drugs not covered $0 copay for Part B-covered drugs.	**Drugs Covered Under Medicare Part B** **General** $0 copay for Part B-covered drugs. **Home Infusion Drugs, Supplies and Services** **General** $0 copay for home infusion drugs that would normally be covered under Part D. This cost-sharing amount will also cover the supplies and services associated with home infusion of these drugs.	**Drugs Covered Under Medicare Part B** **General** $0 copay for Part B-covered drugs. **Home Infusion Drugs, Supplies and Services** **General** $0 copay for home infusion drugs that would normally be covered under Part D. This cost-sharing amount will also cover the supplies and services associated with home infusion of these drugs.

Benefit Category	Original Medicare	Tufts Medicare Preferred HMO Basic (HMO)	Tufts Medicare Preferred HMO Basic Rx (HMO)	Tufts Medicare Preferred HMO Value (HMO)
Outpatient Prescription Drugs cont.	See page 50	**Drugs Covered Under Medicare Part D** **General** This plan does not offer prescription drug coverage.	**Drugs Covered Under Medicare Part D** **General** This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at tuftsmedicarepreferred.org on the web. Different out-of-pocket costs may apply for people who • have limited incomes, • live in long term care facilities, or • have access to Indian/Tribal/ Urban (Indian Health Service). The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).	**Drugs Covered Under Medicare Part D** **General** This plan does not offer prescription drug coverage.

Tufts Medicare Preferred HMO Value Rx (HMO)	Tufts Medicare Preferred HMO Prime (HMO)	Tufts Medicare Preferred HMO Prime Rx (HMO)	Tufts Medicare Preferred HMO Prime Rx Plus (HMO)
Drugs Covered under Medicare Part D **General** This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at tuftsmedicarepreferred.org on the web. Different out-of-pocket costs may apply for people who • have limited incomes, • live in long term care facilities, or • have access to Indian/Tribal/ Urban (Indian Health Service). The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).	**Drugs Covered Under Medicare Part D** **General** This plan does not offer prescription drug coverage.	**Drugs Covered under Medicare Part D** **General** This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at tuftsmedicarepreferred.org on the web. Different out-of-pocket costs may apply for people who • have limited incomes, • live in long term care facilities, or • have access to Indian/Tribal/ Urban (Indian Health Service). The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).	**Drugs Covered under Medicare Part D** **General** This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at tuftsmedicarepreferred.org on the web. Different out-of-pocket costs may apply for people who • have limited incomes, • live in long term care facilities, or • have access to Indian/Tribal/ Urban (Indian Health Service). The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).

Tufts Medicare Preferred HMO (HMO) Plans Benefits Chart

Benefit Category	Original Medicare	Tufts Medicare Preferred HMO Basic (HMO)	Tufts Medicare Preferred HMO Basic Rx (HMO)	Tufts Medicare Preferred HMO Value (HMO)
Outpatient Prescription Drugs cont.	See page 50	See pages 50 & 52	Total yearly drug costs are the total drug costs paid by both you and a Part D plan. The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. Some drugs have quantity limits. Your provider must get prior authorization from Tufts Medicare Preferred HMO Basic Rx (HMO) for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.	See pages 50 & 52

Tufts Medicare Preferred HMO Value Rx (HMO)	Tufts Medicare Preferred HMO Prime (HMO)	Tufts Medicare Preferred HMO Prime Rx (HMO)	Tufts Medicare Preferred HMO Prime Rx Plus (HMO)
Total yearly drug costs are the total drug costs paid by both you and a Part D plan. The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. Some drugs have quantity limits. Your provider must get prior authorization from Tufts Medicare Preferred HMO Value Rx (HMO) for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.	See pages 51 & 53	Total yearly drug costs are the total drug costs paid by both you and a Part D plan. The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. Some drugs have quantity limits. Your provider must get prior authorization from Tufts Medicare Preferred HMO Prime Rx (HMO) for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.	Total yearly drug costs are the total drug costs paid by both you and a Part D plan. The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. Some drugs have quantity limits. Your provider must get prior authorization from Tufts Medicare Preferred HMO Prime Rx Plus (HMO) for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.

Benefit Category	Original Medicare	Tufts Medicare Preferred HMO Basic (HMO)	Tufts Medicare Preferred HMO Basic Rx (HMO)	Tufts Medicare Preferred HMO Value (HMO)
Outpatient Prescription Drugs cont.	See page 50	See pages 50 & 52	If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a formulary exception for a drug and Tufts Medicare Preferred HMO Basic Rx (HMO) approves the exception, you will pay Tier 3: Non-Preferred Brand Drugs cost-sharing for that drug. **In-Network** $0 deductible Supplemental drugs don't count toward your out-of-pocket drug costs. **Initial Coverage** You pay the following until total yearly drug costs reach $2,930: **Retail Pharmacy** **Tier 1: Generic Drugs** • $10 copay for a one-month (30-day) supply of drugs in this tier	See pages 50 & 52

Tufts Medicare Preferred HMO Value Rx (HMO)	Tufts Medicare Preferred HMO Prime (HMO)	Tufts Medicare Preferred HMO Prime Rx (HMO)	Tufts Medicare Preferred HMO Prime Rx Plus (HMO)
If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a formulary exception for a drug and Tufts Medicare Preferred HMO Value Rx (HMO) approves the exception, you will pay Tier 3: Non-Preferred Brand Drugs cost-sharing for that drug. **In-Network** $0 deductible Supplemental drugs don't count toward your out-of-pocket drug costs. **Initial Coverage** You pay the following until total yearly drug costs reach $2,930: **Retail Pharmacy** **Tier 1: Generic Drugs** • $10 copay for a one-month (30-day) supply of drugs in this tier	See pages 51 & 53	If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a formulary exception for a drug and Tufts Medicare Preferred HMO Prime Rx (HMO) approves the exception, you will pay Tier 3: Non-Preferred Brand Drugs cost-sharing for that drug. **In-Network** $0 deductible Supplemental drugs don't count toward your out-of-pocket drug costs. **Initial Coverage** You pay the following until total yearly drug costs reach $2,930: **Retail Pharmacy** **Tier 1: Generic Drugs** • $10 copay for a one-month (30-day) supply of drugs in this tier	If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a formulary exception for a drug and Tufts Medicare Preferred HMO Prime Rx Plus (HMO) approves the exception, you will pay Tier 3: Non-Preferred Brand Drugs cost-sharing for that drug. **In-Network** $0 deductible Supplemental drugs don't count toward your out-of-pocket drug costs. **Initial Coverage** You pay the following until total yearly drug costs reach $2,930: **Retail Pharmacy** **Tier 1: Generic Drugs** • $8 copay for a one-month (30-day) supply of drugs in this tier

Benefit Category	Original Medicare	Tufts Medicare Preferred HMO Basic (HMO)	Tufts Medicare Preferred HMO Basic Rx (HMO)	Tufts Medicare Preferred HMO Value (HMO)
Outpatient Prescription Drugs cont.	See page 50	See pages 50 & 52	• $30 copay for a three-month (90-day) supply of drugs in this tier • $20 copay for a 60-day supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. **Tier 2: Preferred Brand Drugs** • $43 copay for a one-month (30-day) supply of drugs in this tier • $129 copay for a three-month (90-day) supply of drugs in this tier • $86 copay for a 60-day supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. **Tier 3: Non-Preferred Brand Drugs** • $93 copay for a one-month (30-day) supply of drugs in this tier	See pages 50 & 52

Tufts Medicare Preferred HMO Value Rx (HMO)	Tufts Medicare Preferred HMO Prime (HMO)	Tufts Medicare Preferred HMO Prime Rx (HMO)	Tufts Medicare Preferred HMO Prime Rx Plus (HMO)
• $30 copay for a three-month (90-day) supply of drugs in this tier • $20 copay for a 60-day supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. **Tier 2: Preferred Brand Drugs** • $43 copay for a one-month (30-day) supply of drugs in this tier • $129 copay for a three-month (90-day) supply of drugs in this tier • $86 copay for a 60-day supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. **Tier 3: Non-Preferred Brand Drugs** • $93 copay for a one-month (30-day) supply of drugs in this tier	See pages 51 & 53	• $30 copay for a three-month (90-day) supply of drugs in this tier • $20 copay for a 60-day supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. **Tier 2: Preferred Brand Drugs** • $43 copay for a one-month (30-day) supply of drugs in this tier • $129 copay for a three-month (90-day) supply of drugs in this tier • $86 copay for a 60-day supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. **Tier 3: Non-Preferred Brand Drugs** • $93 copay for a one-month (30-day) supply of drugs in this tier	• $24 copay for a three-month (90-day) supply of drugs in this tier • $16 copay for a 60-day supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. **Tier 2: Preferred Brand Drugs** • $35 copay for a one-month (30-day) supply of drugs in this tier • $105 copay for a three-month (90-day) supply of drugs in this tier • $70 copay for a 60-day supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. **Tier 3: Non-Preferred Brand Drugs** • $75 copay for a one-month (30-day) supply of drugs in this tier

Benefit Category	Original Medicare	Tufts Medicare Preferred HMO Basic (HMO)	Tufts Medicare Preferred HMO Basic Rx (HMO)	Tufts Medicare Preferred HMO Value (HMO)
Outpatient Prescription Drugs cont.	See page 50	See pages 50 & 52	• $279 copay for a three-month (90-day) supply of drugs in this tier • $186 copay for a 60-day supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. **Tier 4: Specialty Tier Drugs** • 33% coinsurance for a one-month (30-day) supply of drugs in this tier • 33% coinsurance for a three-month (90-day) supply of drugs in this tier • 33% coinsurance for a 60-day supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.	See pages 50 & 52

Tufts Medicare Preferred HMO Value Rx (HMO)	Tufts Medicare Preferred HMO Prime (HMO)	Tufts Medicare Preferred HMO Prime Rx (HMO)	Tufts Medicare Preferred HMO Prime Rx Plus (HMO)
• $279 copay for a three-month (90-day) supply of drugs in this tier • $186 copay for a 60-day supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. **Tier 4: Specialty Tier Drugs** • 33% coinsurance for a one-month (30-day) supply of drugs in this tier • 33% coinsurance for a three-month (90-day) supply of drugs in this tier • 33% coinsurance for a 60-day supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.	See pages 51 & 53	• $279 copay for a three-month (90-day) supply of drugs in this tier • $186 copay for a 60-day supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. **Tier 4: Specialty Tier Drugs** • 33% coinsurance for a one-month (30-day) supply of drugs in this tier • 33% coinsurance for a three-month (90-day) supply of drugs in this tier • 33% coinsurance for a 60-day supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.	• $225 copay for a three-month (90-day) supply of drugs in this tier • $150 copay for a 60-day supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. **Tier 4: Specialty Tier Drugs** • 33% coinsurance for a one-month (30-day) supply of drugs in this tier • 33% coinsurance for a three-month (90-day) supply of drugs in this tier • 33% coinsurance for a 60-day supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

Tufts Medicare Preferred HMO (HMO) Plans Benefits Chart

Benefit Category	Original Medicare	Tufts Medicare Preferred HMO Basic (HMO)	Tufts Medicare Preferred HMO Basic Rx (HMO)	Tufts Medicare Preferred HMO Value (HMO)
Outpatient Prescription Drugs cont.	See page 50	See pages 50 & 52	**Long Term Care Pharmacy** **Tier 1: Generic Drugs** • $10 copay for a one-month (31-day) supply of drugs in this tier **Tier 2: Preferred Brand Drugs** • $43 copay for a one-month (31-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand Drugs** • $93 copay for a one-month (31-day) supply of drugs in this tier **Tier 4: Specialty Tier Drugs** • 33% coinsurance for a one-month (31-day) supply of drugs in this tier **Mail Order** **Tier 1: Generic Drugs** • $8 copay for a one-month (30-day) supply of drugs in this tier • $24 copay for a three-month (90-day) supply of drugs in this tier • $16 copay for a 60-day supply of drugs in this tier	See pages 50 & 52

Tufts Medicare Preferred HMO Value Rx (HMO)	Tufts Medicare Preferred HMO Prime (HMO)	Tufts Medicare Preferred HMO Prime Rx (HMO)	Tufts Medicare Preferred HMO Prime Rx Plus (HMO)
Long Term Care Pharmacy **Tier 1: Generic Drugs** • $10 copay for a one-month (31-day) supply of drugs in this tier **Tier 2: Preferred Brand Drugs** • $43 copay for a one-month (31-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand Drugs** • $93 copay for a one-month (31-day) supply of drugs in this tier **Tier 4: Specialty Tier Drugs** • 33% coinsurance for a one-month (31-day) supply of drugs in this tier **Mail Order** **Tier 1: Generic Drugs** • $8 copay for a one-month (30-day) supply of drugs in this tier • $24 copay for a three-month (90-day) supply of drugs in this tier • $16 copay for a 60-day supply of drugs in this tier	See pages 51 & 53	**Long Term Care Pharmacy** **Tier 1: Generic Drugs** • $10 copay for a one-month (31-day) supply of drugs in this tier **Tier 2: Preferred Brand Drugs** • $43 copay for a one-month (31-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand Drugs** • $93 copay for a one-month (31-day) supply of drugs in this tier **Tier 4: Specialty Tier Drugs** • 33% coinsurance for a one-month (31-day) supply of drugs in this tier **Mail Order** **Tier 1: Generic Drugs** • $8 copay for a one-month (30-day) supply of drugs in this tier • $24 copay for a three-month (90-day) supply of drugs in this tier • $16 copay for a 60-day supply of drugs in this tier	**Long Term Care Pharmacy** **Tier 1: Generic Drugs** • $8 copay for a one-month (31-day) supply of drugs in this tier **Tier 2: Preferred Brand Drugs** • $35 copay for a one-month (31-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand Drugs** • $75 copay for a one-month (31-day) supply of drugs in this tier **Tier 4: Specialty Tier Drugs** • 33% coinsurance for a one-month (31-day) supply of drugs in this tier **Mail Order** **Tier 1: Generic Drugs** • $7 copay for a one-month (30-day) supply of drugs in this tier • $21 copay for a three-month (90-day) supply of drugs in this tier • $14 copay for a 60-day supply of drugs in this tier

Benefit Category	Original Medicare	Tufts Medicare Preferred HMO Basic (HMO)	Tufts Medicare Preferred HMO Basic Rx (HMO)	Tufts Medicare Preferred HMO Value (HMO)
Outpatient Prescription Drugs cont.	See page 50	See pages 50 & 52	Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. **Tier 2: Preferred Brand Drugs** • $43 copay for a one-month (30-day) supply of drugs in this tier • $129 copay for a three-month (90-day) supply of drugs in this tier • $86 copay for a 60-day supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. **Tier 3: Non-Preferred Brand Drugs** • $93 copay for a one-month (30-day) supply of drugs in this tier • $279 copay for a three-month (90-day) supply of drugs in this tier • $186 copay for a 60-day supply of drugs in this tier	See pages 50 & 52

Tufts Medicare Preferred HMO Value Rx (HMO)	Tufts Medicare Preferred HMO Prime (HMO)	Tufts Medicare Preferred HMO Prime Rx (HMO)	Tufts Medicare Preferred HMO Prime Rx Plus (HMO)
Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. **Tier 2: Preferred Brand Drugs** • $43 copay for a one-month (30-day) supply of drugs in this tier • $129 copay for a three-month (90-day) supply of drugs in this tier • $86 copay for a 60-day supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. **Tier 3: Non-Preferred Brand Drugs** • $93 copay for a one-month (30-day) supply of drugs in this tier • $279 copay for a three-month (90-day) supply of drugs in this tier • $186 copay for a 60-day supply of drugs in this tier	See pages 51 & 53	Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. **Tier 2: Preferred Brand Drugs** • $43 copay for a one-month (30-day) supply of drugs in this tier • $129 copay for a three-month (90-day) supply of drugs in this tier • $86 copay for a 60-day supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. **Tier 3: Non-Preferred Brand Drugs** • $93 copay for a one-month (30-day) supply of drugs in this tier • $279 copay for a three-month (90-day) supply of drugs in this tier • $186 copay for a 60-day supply of drugs in this tier	Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. **Tier 2: Preferred Brand Drugs** • $35 copay for a one-month (30-day) supply of drugs in this tier • $105 copay for a three-month (90-day) supply of drugs in this tier • $70 copay for a 60-day supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. **Tier 3: Non-Preferred Brand Drugs** • $75 copay for a one-month (30-day) supply of drugs in this tier • $225 copay for a three-month (90-day) supply of drugs in this tier • $150 copay for a 60-day supply of drugs in this tier

Benefit Category	Original Medicare	Tufts Medicare Preferred HMO Basic (HMO)	Tufts Medicare Preferred HMO Basic Rx (HMO)	Tufts Medicare Preferred HMO Value (HMO)
Outpatient Prescription Drugs cont.	See page 50	See pages 50 & 52	Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. **Tier 4: Specialty Tier Drugs** • 33% coinsurance for a one-month (30-day) supply of drugs in this tier • 33% coinsurance for a three-month (90-day) supply of drugs in this tier • 33% coinsurance for a 60-day supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. **Coverage Gap** After your total yearly drug costs reach $2,930, you receive a discount on brand name drugs and pay 86% of the plan's cost for all generic drugs until your yearly out-of-pocket drug costs reach $4,700.	See pages 50 & 52

Tufts Medicare Preferred HMO Value Rx (HMO)	Tufts Medicare Preferred HMO Prime (HMO)	Tufts Medicare Preferred HMO Prime Rx (HMO)	Tufts Medicare Preferred HMO Prime Rx Plus (HMO)
Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. **Tier 4: Specialty Tier Drugs** • 33% coinsurance for a one-month (30-day) supply of drugs in this tier • 33% coinsurance for a three-month (90-day) supply of drugs in this tier • 33% coinsurance for a 60-day supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. **Coverage Gap** After your total yearly drug costs reach $2,930, you receive a discount on brand name drugs and pay 86% of the plan's cost for all generic drugs until your yearly out-of-pocket drug costs reach $4,700.	See pages 51 & 53	Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. **Tier 4: Specialty Tier Drugs** • 33% coinsurance for a one-month (30-day) supply of drugs in this tier • 33% coinsurance for a three-month (90-day) supply of drugs in this tier • 33% coinsurance for a 60-day supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. **Coverage Gap** After your total yearly drug costs reach $2,930, you receive a discount on brand name drugs and pay 86% of the plan's cost for all generic drugs until your yearly out-of-pocket drug costs reach $4,700.	Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. **Tier 4: Specialty Tier Drugs** • 33% coinsurance for a one-month (30-day) supply of drugs in this tier • 33% coinsurance for a three-month (90-day) supply of drugs in this tier • 33% coinsurance for a 60-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. **Additional Coverage Gap** You pay the following: **Retail Pharmacy** **Tier 1: Generic Drugs** • $8 copay for a one-month (30-day) supply of all drugs covered in this tier

Tufts Medicare Preferred HMO (HMO) Plans Benefits Chart

Benefit Category	Original Medicare	Tufts Medicare Preferred HMO Basic (HMO)	Tufts Medicare Preferred HMO Basic Rx (HMO)	Tufts Medicare Preferred HMO Value (HMO)
Outpatient Prescription Drugs cont.	See page 50	See pages 50 & 52	**Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,700, you pay the greater of: • 5% coinsurance, or • A $2.60 copay for generic (including brand drugs treated as generic) and a $6.50 copay for all other drugs **Out-of-Network** Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Tufts Medicare Preferred HMO Basic Rx (HMO).	See pages 50 & 52

Tufts Medicare Preferred HMO Value Rx (HMO)	Tufts Medicare Preferred HMO Prime (HMO)	Tufts Medicare Preferred HMO Prime Rx (HMO)	Tufts Medicare Preferred HMO Prime Rx Plus (HMO)
Catastrophic Coverage After your yearly out-of-pocket drug costs reach $4,700, you pay the greater of: • 5% coinsurance, or • A $2.60 copay for generic (including brand drugs treated as generic) and a $6.50 copay for all other drugs **Out-of-Network** Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Tufts Medicare Preferred HMO Value Rx (HMO).	See pages 51 & 53	**Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,700, you pay the greater of: • 5% coinsurance, or • A $2.60 copay for generic (including brand drugs treated as generic) and a $6.50 copay for all other drugs **Out-of-Network** Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Tufts Medicare Preferred HMO Prime Rx (HMO).	• $24 copay for a three-month (90-day) supply of all drugs covered in this tier • $16 copay for a 60-day supply of all drugs covered in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. **Long Term Care Pharmacy** **Tier 1: Generic Drugs** • $8 copay for a one-month (31-day) supply of all drugs covered in this tier **Mail Order** **Tier 1: Generic Drugs** • $7 copay for a one-month (30-day) supply of all drugs covered in this tier • $21 copay for a three-month (90-day) supply of all drugs covered in this tier • $14 copay for a 60-day supply of all drugs covered in this tier

Benefit Category	Original Medicare	Tufts Medicare Preferred HMO Basic (HMO)	Tufts Medicare Preferred HMO Basic Rx (HMO)	Tufts Medicare Preferred HMO Value (HMO)
Outpatient Prescription Drugs cont.	See page 50	See pages 50 & 52	**Out-of-Network** **Initial Coverage** You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,930: **Tier 1: Generic Drugs** • $10 copay for a one-month (30-day) supply of drugs in this tier **Tier 2: Preferred Brand Drugs** • $43 copay for a one-month (30-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand Drugs** • $93 copay for a one-month (30-day) supply of drugs in this tier **Tier 4: Specialty Tier Drugs** • 33% coinsurance for a one-month (30-day) supply of drugs in this tier You will not be reimbursed for the difference between the Out-of-Network pharmacy charge and the plan's In-Network allowable amount.	See pages 50 & 52

Tufts Medicare Preferred HMO Value Rx (HMO)	Tufts Medicare Preferred HMO Prime (HMO)	Tufts Medicare Preferred HMO Prime Rx (HMO)	Tufts Medicare Preferred HMO Prime Rx Plus (HMO)
Out-of-Network **Initial Coverage** You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,930: **Tier 1: Generic Drugs** • $10 copay for a one-month (30-day) supply of drugs in this tier **Tier 2: Preferred Brand Drugs** • $43 copay for a one-month (30-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand Drugs** • $93 copay for a one-month (30-day) supply of drugs in this tier **Tier 4: Specialty Tier Drugs** • 33% coinsurance for a one-month (30-day) supply of drugs in this tier You will not be reimbursed for the difference between the Out-of-Network pharmacy charge and the plan's In-Network allowable amount.	See pages 51 & 53	**Out-of-Network** **Initial Coverage** You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,930: **Tier 1: Generic Drugs** • $10 copay for a one-month (30-day) supply of drugs in this tier **Tier 2: Preferred Brand Drugs** • $43 copay for a one-month (30-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand Drugs** • $93 copay for a one-month (30-day) supply of drugs in this tier **Tier 4: Specialty Tier Drugs** • 33% coinsurance for a one-month (30-day) supply of drugs in this tier You will not be reimbursed for the difference between the Out-of-Network pharmacy charge and the plan's In-Network allowable amount.	Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. After your total yearly drug costs reach $2,930, you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand name drugs and generally pay no more that 86% of the plan's cost for generic drugs until your yearly out-of-pocket drug costs reach $4,700. **Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,700, you pay the greater of: • 5% coinsurance, or • A $2.60 copay for generic (including brand drugs treated as generic) and a $6.50 copay for all other drugs **Out-of-Network** Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may

Benefit Category	Original Medicare	Tufts Medicare Preferred HMO Basic (HMO)	Tufts Medicare Preferred HMO Basic Rx (HMO)	Tufts Medicare Preferred HMO Value (HMO)
Outpatient Prescription Drugs cont.	See page 50	See pages 50 & 52	**Additional Out-of-Network Coverage Gap** You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly drug costs reach $4,700. You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,700. You will not be reimbursed for the difference between the Out-of-Network pharmacy charge and the plan's In-Network allowable amount.	See pages 50 & 52

Tufts Medicare Preferred HMO Value Rx (HMO)	Tufts Medicare Preferred HMO Prime (HMO)	Tufts Medicare Preferred HMO Prime Rx (HMO)	Tufts Medicare Preferred HMO Prime Rx Plus (HMO)
Additional Out-of-Network Coverage Gap You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly drug costs reach $4,700. You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,700. You will not be reimbursed for the difference between the Out-of-Network pharmacy charge and the plan's In-Network allowable amount.	See pages 51 & 53	**Additional Out-of-Network Coverage Gap** You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly drug costs reach $4,700. You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,700. You will not be reimbursed for the difference between the Out-of-Network pharmacy charge and the plan's In-Network allowable amount.	have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Tufts Medicare Preferred HMO Prime Rx Plus (HMO). **Out-of-Network Initial Coverage** You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,930: **Tier 1: Generic Drugs** • $8 copay for a one-month (30-day) supply of drugs in this tier **Tier 2: Preferred Brand Drugs** • $35 copay for a one-month (30-day) supply of drugs in this tier

Benefit Category	Original Medicare	Tufts Medicare Preferred HMO Basic (HMO)	Tufts Medicare Preferred HMO Basic Rx (HMO)	Tufts Medicare Preferred HMO Value (HMO)
Outpatient Prescription Drugs cont.	See page 50	See pages 50 & 52	**Out-of-Network Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,700, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost-share which is the greater of: • 5% coinsurance, or • A $2.60 copay for generic (including brand drugs treated as generic) and a $6.50 copay for all other drugs You will not be reimbursed for the difference between the Out-of-Network pharmacy charge and the plan's In-Network allowable amount.	See pages 50 & 52

Tufts Medicare Preferred HMO Value Rx (HMO)	Tufts Medicare Preferred HMO Prime (HMO)	Tufts Medicare Preferred HMO Prime Rx (HMO)	Tufts Medicare Preferred HMO Prime Rx Plus (HMO)
Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach $4,700, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost-share which is the greater of: • 5% coinsurance, or • A $2.60 copay for generic (including brand drugs treated as generic) and a $6.50 copay for all other drugs You will not be reimbursed for the difference between the Out-of-Network pharmacy charge and the plan's In-Network allowable amount.	See pages 51 & 53	**Out-of-Network Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,700, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost-share which is the greater of: • 5% coinsurance, or • A $2.60 copay for generic (including brand drugs treated as generic) and a $6.50 copay for all other drugs You will not be reimbursed for the difference between the Out-of-Network pharmacy charge and the plan's In-Network allowable amount.	**Tier 3: Non-Preferred Brand Drugs** • $75 copay for a one-month (30-day) supply of drugs in this tier **Tier 4: Specialty Tier Drugs** • 33% coinsurance for a one-month (30-day) supply of drugs in this tier You will not be reimbursed for the difference between the Out-of-Network pharmacy charge and the plan's In-Network allowable amount. **Additional Out-of-Network Coverage Gap** You will be reimbursed for these drugs purchased out-of-network up to the plan's cost of the drug minus the following: **Tier 1: Generic Drugs** • $8 copay for a one-month (up to a 30 day) supply of all drugs covered in this tier

Benefit Category	Original Medicare	Tufts Medicare Preferred HMO Basic (HMO)	Tufts Medicare Preferred HMO Basic Rx (HMO)	Tufts Medicare Preferred HMO Value (HMO)
Outpatient Prescription Drugs cont.	See page 50	See pages 50 & 52	See pages 50-74	See pages 50 & 52

Tufts Medicare Preferred HMO Value Rx (HMO)	Tufts Medicare Preferred HMO Prime (HMO)	Tufts Medicare Preferred HMO Prime Rx (HMO)	Tufts Medicare Preferred HMO Prime Rx Plus (HMO)
See pages 51-75	See pages 51 & 53	See pages 51-75	**Tier 2: Preferred Brand Drugs** You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly drug costs reach $4,700. You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly drug costs reach $4,700. **Tier 3: Non Preferred Brand Drugs** You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly drug costs reach $4,700. You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly drug costs reach $4,700.

Tufts Medicare Preferred HMO (HMO) Plans Benefits Chart

Benefit Category	Original Medicare	Tufts Medicare Preferred HMO Basic (HMO)	Tufts Medicare Preferred HMO Basic Rx (HMO)	Tufts Medicare Preferred HMO Value (HMO)
Outpatient Prescription Drugs cont.	See page 50	See pages 50 & 52	See pages 50-74	See pages 50 & 52

Tufts Medicare Preferred HMO Value Rx (HMO)	Tufts Medicare Preferred HMO Prime (HMO)	Tufts Medicare Preferred HMO Prime Rx (HMO)	Tufts Medicare Preferred HMO Prime Rx Plus (HMO)
See pages 51-75	See pages 51 & 53	See pages 51-75	**Tier 4: Specialty Tier Drugs** You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly drug costs reach $4,700. You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly drug costs reach $4,700. You will not be reimbursed for the difference between the Out-of-Network pharmacy charge and the plan's In-Network allowable amount.

Tufts Medicare Preferred HMO (HMO) Plans Benefits Chart

Benefit Category	Original Medicare	Tufts Medicare Preferred HMO Basic (HMO)	Tufts Medicare Preferred HMO Basic Rx (HMO)	Tufts Medicare Preferred HMO Value (HMO)
Outpatient Prescription Drugs cont.	See page 50	See pages 50 & 52	See pages 50-74	See pages 50 & 52

Tufts Medicare Preferred HMO Value Rx (HMO)	Tufts Medicare Preferred HMO Prime (HMO)	Tufts Medicare Preferred HMO Prime Rx (HMO)	Tufts Medicare Preferred HMO Prime Rx Plus (HMO)
See pages 51-75	See pages 51 & 53	See pages 51-75	**Out-of-Network Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,700, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost-share which is the greater of: • 5% coinsurance, or • A $2.60 copay for generic (including brand drugs treated as generic) and a $6.50 copay for all other drugs You will not be reimbursed for the difference between the Out-of-Network pharmacy charge and the plan's In-Network allowable amount.

Tufts Medicare Preferred HMO (HMO) Plans Benefits Chart

Benefit Category	Original Medicare	Tufts Medicare Preferred HMO Basic (HMO)	Tufts Medicare Preferred HMO Basic Rx (HMO)	Tufts Medicare Preferred HMO Value (HMO)
26 - Dental Services	Preventive dental services (such as cleaning) not covered.	**In-Network** In general, preventive dental benefits (such as cleaning) not covered. $30 copay for Medicare-covered dental benefits.	**In-Network** In general, preventive dental benefits (such as cleaning) not covered. $30 copay for Medicare-covered dental benefits.	**In-Network** In general, preventive dental benefits (such as cleaning) not covered. $20 copay for Medicare-covered dental benefits.
27 - Hearing Services	Supplemental routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams.	**In-Network** Hearing aids not covered. $30 copay for Medicare-covered diagnostic hearing exams. $30 copay for up to 1 supplemental routine hearing exam(s) every year.	**In-Network** Hearing aids not covered. $30 copay for Medicare-covered diagnostic hearing exams. $30 copay for up to 1 supplemental routine hearing exam(s) every year.	**In-Network** Hearing aids not covered. $20 copay for Medicare-covered diagnostic hearing exams. $20 copay for up to 1 supplemental routine hearing exam(s) every year.

Tufts Medicare Preferred HMO Value Rx (HMO)	Tufts Medicare Preferred HMO Prime (HMO)	Tufts Medicare Preferred HMO Prime Rx (HMO)	Tufts Medicare Preferred HMO Prime Rx Plus (HMO)
In-Network In general, preventive dental benefits (such as cleaning) not covered. $20 copay for Medicare-covered dental benefits.	**In-Network** In general, preventive dental benefits (such as cleaning) not covered. $15 copay for Medicare-covered dental benefits.	**In-Network** In general, preventive dental benefits (such as cleaning) not covered. $15 copay for Medicare-covered dental benefits.	**In-Network** In general, preventive dental benefits (such as cleaning) not covered. $15 copay for Medicare-covered dental benefits.
In-Network Hearing aids not covered. $20 copay for Medicare-covered diagnostic hearing exams. $20 copay for up to 1 supplemental routine hearing exam(s) every year.	**In-Network** Hearing aids not covered. $15 copay for Medicare-covered diagnostic hearing exams. $15 copay for up to 1 supplemental routine hearing exam(s) every year.	**In-Network** Hearing aids not covered. $15 copay for Medicare-covered diagnostic hearing exams. $15 copay for up to 1 supplemental routine hearing exam(s) every year.	**In-Network** Hearing aids not covered. $15 copay for Medicare-covered diagnostic hearing exams. $15 copay for up to 1 supplemental routine hearing exam(s) every year.

Benefit Category	Original Medicare	Tufts Medicare Preferred HMO Basic (HMO)	Tufts Medicare Preferred HMO Basic Rx (HMO)	Tufts Medicare Preferred HMO Value (HMO)
28 - Vision Services See page 90 for additional information about Vision Services.	20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. Supplemental routine eye exams and glasses not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. Annual glaucoma screenings covered for people at risk.	**In-Network** $0 copay for • one pair of eye glasses or contact lenses after cataract surgery. • glasses • contacts $0-$30 copay for exams to diagnose and treat diseases and conditions of the eye. $30 copay for up to 1 supplemental routine eye exam(s) every year. $150 plan coverage limit for eye wear every year.	**In-Network** $0 copay for • one pair of eye glasses or contact lenses after cataract surgery. • glasses • contacts $0-$30 copay for exams to diagnose and treat diseases and conditions of the eye. $30 copay for up to 1 supplemental routine eye exam(s) every year. $150 plan coverage limit for eye wear every year.	**In-Network** $0 copay for • one pair of eye glasses or contact lenses after cataract surgery. • glasses • contacts $0-$20 copay for exams to diagnose and treat diseases and conditions of the eye. $20 copay for up to 1 supplemental routine eye exam(s) every year. $150 plan coverage limit for eye wear every year.

Tufts Medicare Preferred HMO Value Rx (HMO)	Tufts Medicare Preferred HMO Prime (HMO)	Tufts Medicare Preferred HMO Prime Rx (HMO)	Tufts Medicare Preferred HMO Prime Rx Plus (HMO)
In-Network $0 copay for • one pair of eye glasses or contact lenses after cataract surgery. • glasses • contacts $0-$20 copay for exams to diagnose and treat diseases and conditions of the eye. $20 copay for up to 1 supplemental routine eye exam(s) every year. $150 plan coverage limit for eye wear every year.	**In-Network** $0 copay for • one pair of eye glasses or contact lenses after cataract surgery. • glasses • contacts $0-$15 copay for exams to diagnose and treat diseases and conditions of the eye. $15 copay for up to 1 supplemental routine eye exam(s) every year. $150 plan coverage limit for eye wear every year.	**In-Network** $0 copay for • one pair of eye glasses or contact lenses after cataract surgery. • glasses • contacts $0-$15 copay for exams to diagnose and treat diseases and conditions of the eye. $15 copay for up to 1 supplemental routine eye exam(s) every year. $150 plan coverage limit for eye wear every year..	**In-Network** $0 copay for • one pair of eye glasses or contact lenses after cataract surgery. • glasses • contacts $0-$15 copay for exams to diagnose and treat diseases and conditions of the eye. $15 copay for up to 1 supplemental routine eye exam(s) every year. $150 plan coverage limit for eye wear every year.

Benefit Category	Original Medicare	Tufts Medicare Preferred HMO Basic (HMO)	Tufts Medicare Preferred HMO Basic Rx (HMO)	Tufts Medicare Preferred HMO Value (HMO)
Over-the Counter Items	Not covered.	**General** This plan does not cover Over-the-Counter items.	**General** This plan does not cover Over-the-Counter items.	**General** This plan does not cover Over-the-Counter items.
Transportation (Routine)	Not covered.	**In-Network** This plan does not cover supplemental routine transportation.	**In-Network** This plan does not cover supplemental routine transportation.	**In-Network** This plan does not cover supplemental routine transportation.
Acupuncture	Not covered.	**In-Network** This plan does not cover Acupuncture.	**In-Network** This plan does not cover Acupuncture.	**In-Network** This plan does not cover Acupuncture.

Tufts Medicare Preferred HMO Value Rx (HMO)	Tufts Medicare Preferred HMO Prime (HMO)	Tufts Medicare Preferred HMO Prime Rx (HMO)	Tufts Medicare Preferred HMO Prime Rx Plus (HMO)
General This plan does not cover Over-the-Counter items.	**General** This plan does not cover Over-the-Counter items.	**General** This plan does not cover Over-the-Counter items.	**General** This plan does not cover Over-the-Counter items.
In-Network This plan does not cover supplemental routine transportation.	**In-Network** This plan does not cover supplemental routine transportation.	**In-Network** This plan does not cover supplemental routine transportation.	**In-Network** This plan does not cover supplemental routine transportation.
In-Network This plan does not cover Acupuncture.	**In-Network** This plan does not cover Acupuncture.	**In-Network** This plan does not cover Acupuncture.	**In-Network** This plan does not cover Acupuncture.

Tufts Medicare Preferred HMO Premium Table By County

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 6-87) of this booklet.

Plan Premiums by County	Plan premiums**
Barnstable	
Tufts Medicare Preferred HMO Basic No Rx (027)	$0
Tufts Medicare Preferred HMO Basic Rx (026)	$27.90
Tufts Medicare Preferred HMO Value No Rx (019)	$72.00
Tufts Medicare Preferred HMO Value Rx (018)	$99.90
Tufts Medicare Preferred HMO Prime No Rx (016)	$112
Tufts Medicare Preferred HMO Prime Rx (015)	$139.90
Tufts Medicare Preferred HMO Prime Rx Plus (001)	$170.40
Hampden	
Tufts Medicare Preferred HMO Basic No Rx (027)	$0
Tufts Medicare Preferred HMO Basic Rx (026)	$27.90
Tufts Medicare Preferred HMO Value No Rx (019)	$24.00
Tufts Medicare Preferred HMO Value Rx (018)	$51.90
Tufts Medicare Preferred HMO Prime No Rx (016)	$54
Tufts Medicare Preferred HMO Prime Rx (015)	$81.90
Tufts Medicare Preferred HMO Prime Rx Plus (001)	$112.40

Plan Premiums by County	Plan premiums**
Hampshire	
Tufts Medicare Preferred HMO Basic No Rx (027)	$0
Tufts Medicare Preferred HMO Basic Rx (026)	$27.90
Tufts Medicare Preferred HMO Value No Rx (019)	$52.00
Tufts Medicare Preferred HMO Value Rx (018)	$79.90
Tufts Medicare Preferred HMO Prime No Rx (016)	$82
Tufts Medicare Preferred HMO Prime Rx (015)	$109.90
Tufts Medicare Preferred HMO Prime Rx Plus (001)	$140.40
Essex, Suffolk, Worcester	
Tufts Medicare Preferred HMO Basic No Rx (027)	$20.00
Tufts Medicare Preferred HMO Basic Rx (026)	$47.90
Tufts Medicare Preferred HMO Value No Rx (019)	$93.00
Tufts Medicare Preferred HMO Value Rx (018)	$120.90
Tufts Medicare Preferred HMO Prime No Rx (016)	$126
Tufts Medicare Preferred HMO Prime Rx (015)	$153.90
Tufts Medicare Preferred HMO Prime Rx Plus (001)	$184.40

** 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*, Middlesex, Norfolk, Plymouth*	
Tufts Medicare Preferred HMO Basic No Rx (027)	$0
Tufts Medicare Preferred HMO Basic Rx (026)	$27.90
Tufts Medicare Preferred HMO Value No Rx (019)	$72.00
Tufts Medicare Preferred HMO Value Rx (018)	$99.90
Tufts Medicare Preferred HMO Prime No Rx (016)	$102
Tufts Medicare Preferred HMO Prime Rx (015)	$129.90
Tufts Medicare Preferred HMO Prime Rx Plus (001)	$160.40

* Asterisks (*) indicate partial county. If you live in one of the following zip codes, you live outside the service area and are not eligible to be a member: Bristol County: 02715, 02718, 02764, 02779, 02780, 02783. Plymouth County: 02344, 02346, 02347, 02348, 02349.
** You must continue to pay your Medicare Part B premium if not otherwise paid for under Medicaid or by a third party.

Important Information About Tufts Medicare Preferred HMO Plans

We are committed to providing a high standard of health care coverage. Tufts Health Plan Medicare Preferred is a local name you can trust!

We've got you covered. In addition to covering all your Medicare benefits, Tufts Medicare Preferred HMO plans also provide the following Health and Wellness benefits (co-payments apply unless noted):

- **Annual routine hearing exam** *(see #27, pp 82-83)*
- **Worldwide emergency and urgent care** *(see page 92)*
- **Annual routine eye exam and eyewear or contact lenses** *(see #28, pp 84-85)*

  As part of your Tufts Medicare Preferred HMO benefits, you are covered for one routine eye exam once per calendar year from a provider in the EyeMed network. Annual glaucoma screenings are covered for individuals at high risk for glaucoma, individuals with family history of glaucoma or individuals with Diabetes.

  The plan also provides up to $150 towards the full retail price once every calendar year, for prescription eyewear (eyeglass lenses, frames, and upgrades) or contact lenses, but not both. Sale items are excluded and this benefit cannot be combined with any other store discounts, coupons, or promotional codes. Eyewear must be purchased from a provider or location that participates in the EyeMed network. This benefit is in addition to, and cannot be combined with, the standard Medicare coverage for post-cataract surgery eyeglasses/ contact lenses or with the Tufts Medicare Preferred HMO coverage for one pair of standard eyeglasses every calendar year or contact lenses per prescription change for Keratoconus, Anisometropia (more than 3.0 diopters) or high myopia (more than 7.0 diopters).

- **$150 Annual fitness and nutritional counseling benefit** *(see #23, page 44-45)*

  Each calendar year you may be reimbursed up to $150 towards fees you pay:
  - To participate in instructional fitness classes such as yoga, Pilates, Tai Chi and aerobics.
  - For membership in a qualified health club or fitness facility. A qualified health club or fitness facility provides cardiovascular and strength training exercise equipment on site.
  - For nutritional counseling provided by a register dietician or licensed nutritional counselor.

  Note: This benefit does not cover membership fees you pay to non-qualified health clubs or fitness facilities, including but not limited to martial arts centers, gymnastics facilities, country clubs and social clubs, and for sports activities such as golf and tennis.

For more savings and to request the fitness and nutritional counseling reimbursement form, please call Customer Service at the number listed on the back cover of this document.

• **Durable medical equipment and prosthetics** *(see #18-19, pp 32-33)*

The following items are not covered by Medicare for the criteria listed.
However, upon written prescription from a Tufts Medicare Preferred HMO physician, we will cover these items when the criteria described below is met.

Category	Criteria	Covered Item(s)
Bathroom Safety Equipment	Member has functional impairment & item will improve safety	• 1 raised toilet seat per member per lifetime • Up to 2 bath grab bars per member per lifetime • 1 tub seat per member per lifetime
Mastectomy Sleeves	Member has lymphedema post-mastectomy	Up to 2 every 6 months
Wigs	Member who experiences hair loss due to cancer or leukemia treatment	Up to $350 each calendar year
Gradient Compression Stockings or Surgical Stockings*	To treat Members with venous insufficiency *without* stasis ulcers, peripheral edema, lymphedema, symptomatic varicosities, post thrombotic syndrome (post phlebitic syndrome), or postural hypotension; and to prevent the reoccurrence of stasis ulcers that have healed.	• Up to 2 pair gradient compression stockings every 6 months, OR • Up to 2 pair surgical stockings every 6 months

*We will continue to cover gradient compression stockings according to Medicare coverage guidelines for venous insufficiency with stasis ulcers.

Further Details about Coverage Described in Section Two of this Summary of Benefits

Annual Out-of-Pocket Maximum *(see #1, pp 6-7)*

The Out-of-Pocket Maximum limits the amount you pay in member cost-sharing for covered services during the year. When you reach the $3,400 Out-of-Pocket Maximum, Tufts Health Plan Medicare Preferred pays 100% for all services covered under the plan. There are certain services you may pay for which do not count towards the Out-of-Pocket Maximum, for example:

- Member premium
- Non-covered services you pay for, and
- Payments you make over the benefit limits for such services such as Skilled Nursing Facility (SNF) days, eyewear, and fitness and nutritional counseling reimbursement, and
- Your copayments and other out-of-pocket costs for prescription drugs as explained on page 94

Inpatient Care *(see #3-7, pp 10-19)*

- *For Inpatient Care in an Acute Hospital*, you are covered for unlimited medically necessary days in a general hospital.

- *For Inpatient Care in a Rehabilitation or Long Term Hospital*, you are covered up to 90 days per benefit period. You may use your 60-lifetime reserve days to supplement care in rehabilitation or long-term hospitals. Coverage is limited by prior partial or complete use of these days, which may only be used once in a lifetime.

- *For Inpatient Care in a Psychiatric Hospital*, you are covered up to a 190-day lifetime limit in a psychiatric hospital for mental health care and substance abuse (limit does not apply to psychiatric services provided in a psychiatric unit of an acute care hospital). You may use your 60-lifetime reserve days to supplement care in rehabilitation or long-term hospitals. Coverage is limited by prior partial or complete use of these days, which may only be used once in a lifetime.

- *For Inpatient Care in a Skilled Nursing Facility,* you are covered up to 100 days per benefit period

Ambulance Services *(see #14, pp 28-29)*

Emergency and non-emergency Ambulance Services are covered according to Medicare guidelines based on medical necessity. If your situation qualifies for coverage, you will pay the copayment stated on pp 28-29. If your situation does not qualify for coverage and you use the ambulance anyway, you will be responsible for the entire cost.

Note: Wheelchair van (chair car) transportation, even if provided by an ambulance company, is not the same as ambulance transportation and is never covered regardless of the circumstance. Ambulance transport to a physician's office is never covered.

Emergency and Urgent Care – Worldwide *(see #15-16, pp 28-31)*

When you reasonably believe your health is in serious danger, seek care immediately. A medical emergency includes severe pain, a bad injury, a serious illness or a medical condition that is quickly getting worse. The plan pays for medically necessary covered services, subject to applicable copayments.

Sometimes it is hard to know if you have a medical emergency. If medical care is required for an urgent situation, such as an unforeseen illness or injury, but your health is not in serious danger, we pay for medically necessary covered services, subject to applicable copayments.

Please be advised, no benefits are provided for services you get outside the United States that:

- Are routine or preventive services;
- You scheduled, or could have scheduled, to receive here in the United States before leaving, even if it meant delaying your travel plans;
- Would not be covered by Medicare or Tufts Health Plan Medicare Preferred in the United States.

Preventive Screenings and Other No Copay Services

(see #23-24 pp 40-49)

Usually you will pay an office visit co-payment when you visit your primary care physician or a specialist. However, you will not pay an office visit co-payment when the only service provided is a Medicare-covered preventive service(s) as described on pp 40-49. Also, no copayment for visits to your PCP or RN/NP when you are only going for INR testing (anti-coagulant visit). Coverage is also provided with no copay for a fall prevention assessment in the home when authorized by your Primary Care Physician (PCP).

We Also Offer Part D Prescription Drug Coverage to Meet Your Needs

When you join a Tufts Medicare Preferred HMO plan, you may choose one of our Medicare Part D prescription drug options. You will have access to participating pharmacies throughout the state and nationwide. We provide mail order service, too, so the medications you take every day come right to your door! When you purchase medications you will pay a copayment as described below. We cover most prescription drugs and we even cover certain drugs which are not covered under Medicare Part D, such as benzodiazapines and barbiturates (which are sedatives).

In an emergency or urgent situation, you may purchase a 30-day supply of medication at an out-of-network pharmacy. However, in addition to the applicable retail copayment, you will pay the difference between the medication cost when purchased at a network pharmacy (our contracted price) and the cost when purchased at an out-of-network pharmacy. If you fill at an out-of-network pharmacy, you may be required to pay the full cost of the medication and then submit for reimbursement minus your cost-share.

Covered and Non-Covered Drugs

The Tufts Medicare Preferred HMO formulary is a list of prescription drugs approved for coverage by Tufts Health Plan Medicare Preferred. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Tufts Medicare Preferred HMO participating pharmacy, and other plan rules are followed. During the year, prescription drugs may be added to the formulary, removed from the formulary or moved from one tier to another. If we remove a drug or move a drug from one tier to a higher cost-sharing tier (example: from Tier 2 to Tier 3), we must notify you at least 60 days before the date that the change becomes effective.

Medical Review Process for Coverage of Prescription Drugs

If your doctor believes a drug included in one of our pharmacy management programs is necessary for your treatment, the doctor may submit a request for coverage to our Precertification Department. We will cover the drug if it meets our medical necessity guidelines. If the request isn't approved, you can appeal the decision. For additional information, please call our Customer Service department or visit our website as indicated on the back cover of this document.

Prescription Drugs *(see #25, pp 50-81)*

	Rx: Can be combined with Tufts Medicare Preferred HMO Prime, Value or Basic plans				Rx Plus: Can be combined with Tufts Medicare Preferred HMO Prime plan only			
	You pay no deductible. You are covered up to $2,930 of drug costs paid by you and the Plan. You pay:							
Retail	**Tier 1**	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 1**	**Tier 2**	**Tier 3**	**Tier 4**
30-day supply	$10	$43	$93	33%	$8	$35	$75	33%
60-day supply	$20	$86	$186	33%	$16	$70	$150	33%
90-day supply	$30	$129	$279	33%	$24	$105	$225	33%
Mail Order	**Tier 1**	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 1**	**Tier 2**	**Tier 3**	**Tier 4**
30-day supply	$8	$43	$93	33%	$7	$35	$75	33%
60-day supply	$16	$86	$186	33%	$14	$70	$150	33%
90-day supply	$24	$129	$279	33%	$21	$105	$225	33%
In the Coverage Gap	**After you reach $2,930 and until your payments reach $4,700*, you pay:**							
	• 86% for Part D generic drugs • 100% for Part D brand drugs. The price you pay may include a 50% discount provided by drug manufacturers.				• Tier 1 copayments for Tier 1 drugs (generics) • 86% for all other Part D generic drugs • 100% for Part D brand drugs. The price you pay may include a 50% discount provided by drug manufacturers.			
After the Coverage Gap	**When your payments for the year are greater than $4,700*, you pay the greater of:**							
	5% coinsurance per prescription, or $2.60 for Part D generic drugs and $6.50 for Part D brand drugs							

* The amount discounted by the manufacturer in the Coverage Gap counts towards your out-of-pocket costs as if you had paid the total amount of the drug yourself. This helps you move through the gap.

Please Note: When purchasing at a retail location, you will pay, whichever is lower, either the copay or the amount charged by the retailer.

Referral Circles

You choose a Primary Care Physician (PCP) from among the more than 1,600 PCPs in our plan (if you don't currently have a PCP, our representatives can help you find one to meet your needs). **The PCP you choose works with certain plan specialists, called a "referral circle," to provide the medical care you need.** This means in most cases, 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. If you obtain routine care from out-of-network providers neither Medicare nor Tufts Health Plan Medicare Preferred will be responsible for the costs. This coordinated approach to care helps ensure that you receive the right level of care in the right setting at the right time.

Limitations and Exclusions

The benefits listed in this Summary of Benefits 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 of the limitations and exclusions. If you have questions about limitations and exclusions, please contact us at the phone number on the back of this booklet.

Service Area

The service area for Tufts Medicare Preferred HMO plans include the following counties: Barnstable, Bristol*, Essex, Hampden, Hampshire, Middlesex, Norfolk, Plymouth*, Suffolk, and Worcester Counties, MA. You must live in one of these areas to join a Tufts Medicare Preferred HMO plan. Asterisk (*) indicates partial county. If you live in one of the following zip codes, you live outside the service area and are not eligible to be a member: Bristol County: 02715, 02718, 02764, 02779, 02780, 02783. Plymouth County: 02344, 02346, 02347, 02348, 02349.

Contract Renewal

The Medicare Advantage contract between Tufts Health Plan Medicare Preferred and the Centers for Medicare & Medicaid Services (CMS) is renewed annually. Tufts Health Plan Medicare Preferred is authorized by law to refuse to renew its contract with CMS and CMS also may refuse to renew the contract. Termination or non-renewal may result in termination of the beneficiary's enrollment in the Plan. The availability of coverage beyond the end of the contract year is not guaranteed. Please contact Tufts Health Plan Medicare Preferred for details.

Privacy Policy

Our Privacy Policy is posted on our website. If you do not have access to the Web, please contact us at the phone number on the back of this booklet to receive a copy in the mail.

Notes:

Notes:

TUFTS HEALTH PLAN MEDICARE PREFERRED...

We're here to help.

If you have any questions, please call us toll free and we will be happy to assist you. 1-800-978-2222. The hearing impaired may call: TTY 1-888-899-8977. Representatives are available Monday – Friday, 8 a.m. – 8 p.m. (From October 15 – 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.

Or visit our website at tuftsmedicarepreferred.org.

Visit us online at

tuftsmedicarepreferred.org

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705 Mount Auburn Street, Watertown, MA 02472