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# 2024 Summary of Benefits

Tufts Medicare Preferred HMO Plans

## Employer Group

### Tufts Medicare Preferred HMO Prime

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover, or list every limitation or exclusion. To get a complete list of services we cover, please visit [www.thpmp.org](http://www.thpmp.org) to view the *Evidence of Coverage*. You can also request a printed copy by calling Member Services at 1-800-701-9000 (TTY: 711), 8:00 a.m. – 8:00 p.m., 7 days a week from October 1 to March 31 and Monday-Friday from April 1 to September 30.

Effective January 1, 2024–December 31, 2024

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## Summary of Benefits

January 1, 2024–December 31, 2024

### You have choices about how to get your Medicare benefits

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

### Tips for comparing your Medicare choices

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

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

## Things to Know About Tufts Medicare Preferred HMO Prime

### Who can join?

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

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

### Which doctors, hospitals, and pharmacies can I use?

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

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

### Referral circles

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

### What do we cover?

We cover everything that Original Medicare covers—and more.

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

Tufts Medicare Preferred HMO Prime covers Part B drugs such as chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, [www.thpmp.org](http://www.thpmp.org).

### How will I determine my drug costs for Tufts Medicare Preferred HMO Prime?

Our plan groups each medication into one of three "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached.

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

<b>Monthly Plan Premium</b>	
	Please see your employer for your premium amount.
<b>Deductible</b>	
	\$300 per year for inpatient hospital care
<b>Maximum Out-of-Pocket Responsibility</b> (does not include prescription drugs)	\$3,400
<i>What You Should Know</i>	Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. If you reach the limit on out-of-pocket costs, we will pay the full cost of your covered hospital and medical services for the rest of the year. Please note that you will still need to pay your monthly premiums (and cost-sharing for your Part D prescription drugs, if applicable).
<b>Inpatient and Outpatient Care and Services</b>	
<b>Inpatient Hospital Care</b>	
<b>Inpatient hospital care</b>	\$300 annual deductible, then you pay nothing.
<i>What You Should Know</i>	Our plan covers an unlimited number of days for an inpatient hospital stay. You will not pay more than \$300 (after your deductible) for inpatient hospital covered services in a calendar year. Prior authorization may be required.
<b>Outpatient Hospital Care</b>	
<b>Outpatient hospital services</b>	\$50 copay per day
<b>Outpatient surgery</b> (services provided at hospital outpatient facilities)	\$50 copay per day
<b>Ambulatory surgical center (ASC) services</b>	\$50 copay per day
<i>What You Should Know</i>	Before you receive services, you must obtain a referral from your PCP. Prior authorization may be required.
<b>Doctor Visits</b>	
<b>Primary care physician</b>	\$10 copay per visit
<b>Specialist</b>	\$15 copay per visit
<i>What You Should Know</i>	There is no copay for an annual physical exam with your PCP. Office visit copay applies for surgery services furnished in the physician's office. Before you receive services from a specialist, you must obtain a referral from your PCP.
<b>Preventive care</b>	You pay nothing
<i>What You Should Know</i>	Any additional preventive services approved by Medicare during the contract year will be covered.
<b>Emergency care</b>	\$50 copay per visit
<i>What You Should Know</i>	If you are admitted to the hospital within 24 hours for the same condition, you do not have to pay your share of the cost for emergency care. Your plan includes worldwide coverage for emergency care.

<b>Inpatient and Outpatient Care and Services</b>	
<b>Urgently needed services</b>	\$15 copay per visit
<i>What You Should Know</i>	Urgently needed care may be furnished by in-network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. Copayment is not waived if admitted as an inpatient within 24 hours. Your plan includes worldwide coverage for urgently needed care.
<b>Diagnostic Services/Labs/Imaging</b>	
<b>Diagnostic radiology services</b> (such as MRIs, CT scans)	You pay nothing
<b>Diagnostic tests and procedures</b>	You pay nothing
<b>Lab services</b>	You pay nothing
<b>Outpatient X-rays</b>	You pay nothing
<i>What You Should Know</i>	Prior authorization may be required.
<b>Hearing Services</b>	
<b>Exam to diagnose and treat hearing and balance issues</b>	\$15 copay per visit
<b>Routine hearing exam</b> (up to 1 every year)	\$15 copay per visit
<b>Hearing aids</b>	Up to \$500 every three years toward the purchase or repair of hearing aids.
<b>Dental</b>	
<b>Limited Medicare-covered dental services</b>	\$15 copay per visit
<i>What You Should Know</i>	Limited Medicare-covered dental services do not include preventive dental services such as cleaning, routine dental exams, and dental X-rays.
<b>Vision Services</b>	
<b>Routine eye exam</b> (up to 1 every year)	\$15 copay per visit
<b>Exam to diagnose and treat diseases and conditions of the eye</b>	\$15 copay per visit
<b>Annual glaucoma screening</b>	\$0 copay per visit
<b>Annual eyewear benefit</b>	Up to \$150 allowance per calendar year
<i>What You Should Know</i>	You must use a participating vision care provider (EyeMed Vision Care) to receive the covered Routine Eye Exam benefit. You must purchase your glasses (prescription lenses, frames, or a combination of lenses and frames) and/or contacts from a participating vision provider (EyeMed Vision Care) to receive the \$150 allowance. Otherwise, the benefit will be limited to \$90 per year. You need a referral from your PCP for a diagnostic eye exam.

<b>Inpatient and Outpatient Care and Services</b>	
<b>Mental Health Services</b>	
<b>Inpatient visit</b>	You pay nothing
<b>Outpatient group or individual therapy visit</b>	\$15 copay per visit
<i>What You Should Know</i>	Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental health services provided in a general hospital.  Before you receive services from a psychiatrist, you must obtain a referral from your PCP. A referral is not required for all other Outpatient Mental Health Care services.
<b>Skilled Nursing Facility (SNF)</b>	
<b>Skilled nursing facility (SNF)</b>	You pay nothing
<i>What You Should Know</i>	Our plan covers up to 100 days in a SNF per benefit period. No prior hospital stay is required. Prior authorization may be required.
<b>Physical Therapy</b>	
<b>Occupational therapy</b>	\$15 copay per visit
<b>Physical therapy and speech and language therapy</b>	\$15 copay per visit
<i>What You Should Know</i>	Before you receive occupational therapy, physical therapy, or speech and language therapy services, you must obtain a referral from your PCP.
<b>Ambulance</b>	
<b>Ambulance</b>	\$50 copay per day
<i>What You Should Know</i>	Prior authorization may be required for non-emergency transportation.
<b>Transportation</b>	
<b>Transportation</b>	Not covered
<b>Medicare Part B Drugs</b>	
<b>Medicare Part B drugs</b>	For Part B chemotherapy drugs: You pay nothing.  Other Part B drugs: You pay nothing.
<i>What You Should Know</i>	Prior authorization may be required. Part B drugs may be subject to Step Therapy requirements.

<b>Prescription Drug Benefits</b>	Please see the Plan Highlights in your enrollment kit for additional information.
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<b>Additional Benefits</b>	
<b>Acupuncture</b>	
<b>Acupuncture services</b>	\$15 copay per visit
<i>What You Should Know</i>	<p>Medicare covers up to 12 visits in 90 days for members with chronic low back pain. 8 additional visits covered for those demonstrating an improvement. No more than 20 visits administered annually.</p> <p>Before you receive services from a specialist, you must obtain a referral from your PCP.</p> <p>The plan will reimburse services rendered and billed directly by a licensed acupuncturist when there is a referral from your PCP.</p> <p>Additional acupuncture services are eligible for reimbursement under the annual Wellness Allowance benefit. See additional details under "Wellness Programs."</p>
<b>Chiropractic Care</b>	
<b>Manual manipulation of the spine to correct a subluxation</b> (when 1 or more of the bones of your spine move out of position)	\$15 copay per visit
<i>What You Should Know</i>	Before you receive services from a specialist, you must obtain a referral from your PCP.
<b>Foot Care (podiatry services)</b>	
<b>Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions</b>	\$15 copay per visit
<i>What You Should Know</i>	Before you receive services from a specialist, you must obtain a referral from your PCP.
<b>Home Health Services</b>	
<b>Home health agency care</b>	You pay nothing
<b>Home infusion therapy</b>	You pay nothing
<i>What You Should Know</i>	Prior authorization may be required for home infusion therapy services.
<b>Hospice</b>	
	Benefit provided by Medicare
<i>What You Should Know</i>	You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.
<b>Medical Equipment/Supplies</b>	
<b>Durable medical equipment</b> (e.g., wheelchairs, oxygen)	You pay nothing
<b>Prosthetic devices</b> (e.g., braces, artificial limbs, etc.)	You pay nothing

<b>Additional Benefits</b>	
<i>What You Should Know</i>	<p>Additional items covered by the plan: bathroom safety equipment for members who have a functional impairment when having the item will improve safety:</p> <ul style="list-style-type: none"> <li>• Raised toilet seat: 1 per member per lifetime</li> <li>• Bathroom grab bars: 2 per member per lifetime</li> <li>• Tub seat: 1 per member per lifetime</li> </ul> <p>The following additional items are covered by the plan:</p> <ul style="list-style-type: none"> <li>• Gradient compression stockings or surgical stockings: up to 2 pairs every 6 months</li> <li>• Mastectomy sleeves for members with upper limb lymphedema: up to 2 sleeves every 6 months</li> </ul> <p>Prior authorization may be required.</p>
<b>Wig allowance</b> (for hair loss due to cancer treatment)	\$350 per year
<b>Diabetes services and supplies</b>	You pay nothing
<i>What You Should Know</i>	<p>Includes diabetes monitoring supplies, diabetes self-management training, and therapeutic shoes or inserts. Copay may apply if you receive other medical services during the same office visit. Referral required for diabetes self-management training only.</p> <p>Coverage for blood glucose monitors and blood glucose tests strips is limited to the OneTouch products manufactured by LifeScan, Inc. Please note that there is no preferred brand for lancets.</p> <p>Covered therapeutic Continuous Glucose Monitors (CGMs) include Dexcom and FreeStyle Libre products that are considered Durable Medical Equipment (DME) by Medicare. Prior authorization is required for CGMs.</p> <p>Diabetic testing supplies, including test strips, lancets, glucose meters, and therapeutic Continuous Glucose Monitoring Systems are also covered at participating retail or mail-order pharmacies.</p>
<b>Outpatient Substance Abuse</b>	
<b>Group or individual therapy visit</b>	\$15 copay per visit
<b>Renal Dialysis</b>	
	You pay nothing
<b>Telehealth/Telemedicine Services</b>	
	<p>Medicare-covered services plus additional telehealth services including PCP services, specialist services, and more.</p> <p>\$0 copay for e-visits and virtual check-ins; For all other telehealth visits, copay is the same as corresponding in-person visit copay. Referral is required for some additional telehealth services.</p>
<b>Wellness Programs</b>	
<b>Weight Management program</b>	The plan provides a \$150 annual Weight Management allowance towards program fees for weight loss programs such as WeightWatchers® or a hospital-based weight loss program.
<b>Wellness Allowance</b>	The plan provides a \$150 annual Wellness Allowance toward health club memberships, participation in online instructional fitness classes or membership fees for online fitness subscriptions, such as Peloton, nutritional counseling, acupuncture, or fitness classes like Pilates, tai chi, or aerobics, and wellness programs, including memory fitness activities.



## Questions

Visit us at [www.thpmp.org](http://www.thpmp.org), or call 1-800-936-1902 (TTY: 711).



1 Wellness Way  
Canton, MA 02021

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Tufts Health Plan is an HMO plan with a Medicare contract. Enrollment in Tufts Health Plan depends on contract renewal. This information is not a complete description of benefits. Call 1-800-701-9000 (TTY: 711) for more information. Tufts Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-701-9000 (TTY: 711).