TUFTS Health Plan

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2026 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** 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, 2026–December 31, 2026

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Summary of Benefits

January 1, 2026–December 31, 2026

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**.
- If you want to know more about the coverage and costs of Original Medicare, look in your current *Medicare & You* handbook. View it online at **www.medicare.gov** or get a copy by calling **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

Things to Know About Tufts 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**).

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**.

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.

Monthly Plan Premium	
	Please see your employer for your premium amount.
Deductible	
	$300 per year for inpatient hospital care
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$3,400
What You Should Know	Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. If you reach the limit on out-of-pocket costs, we will pay the full cost of your covered hospital and medical services for the rest of the year. Please note that you will still need to pay your monthly premiums (and cost-sharing for your Part D prescription drugs, if applicable).
Inpatient and Outpatient Care and Services	
Inpatient Hospital Care	
Inpatient hospital care	$300 annual deductible, then you pay nothing.
What You Should Know	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.
Outpatient Hospital Care	
Outpatient hospital services	$50 copay per day
Outpatient surgery (services provided at hospital outpatient facilities)	$50 copay per day
Ambulatory surgical center (ASC) services	$50 copay per day
What You Should Know	A referral may be required from your PCP before you receive these services. Your PCP will provide this referral if needed. Prior authorization may be required.
Doctor Visits	
Primary care physician	$10 copay per visit
Specialist	$15 copay per visit
What You Should Know	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. A referral may be required from your PCP before you receive services from a specialist. Your PCP will provide this referral if needed
Preventive care (Medicare preventive services)	You pay nothing
What You Should Know	Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency care	$50 copay per visit
What You Should Know	If you are held for observation or admitted to the hospital within one day for the same condition, the emergency care copay will be waived and the applicable observation or inpatient cost share will apply. Your plan includes worldwide coverage for emergency care.

Inpatient and Outpatient Care and Services	
Urgently needed services	$15 copay per visit
What You Should Know	Urgently needed care may be furnished by in-network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. Copayment is not waived if admitted as an inpatient within one day. Your plan includes worldwide coverage for urgently needed care.
Diagnostic Services/Labs/Imaging	
Diagnostic radiology services (such as MRIs, CT scans)	You pay nothing
Diagnostic tests and procedures	You pay nothing
Lab services	You pay nothing
Outpatient X-rays	You pay nothing
What You Should Know	Prior authorization may be required.
Hearing Services	
Exam to diagnose and treat hearing and balance issues	$15 copay per visit
Routine hearing exam (up to 1 every year)	$15 copay per visit
Hearing aids	Up to $500 every three years toward the purchase or repair of hearing aids.
Dental	
Limited Medicare-covered dental services	$15 copay per visit
What You Should Know	Prior authorization may be required. Limited Medicare-covered dental services do not include preventive dental services such as cleaning, routine dental exams, and dental X-rays. A referral may be required from your PCP before you receive these services. Your PCP will provide this referral if needed.
Vision Services	
Routine eye exam (up to 1 every year)	$15 copay per visit
Exam to diagnose and treat diseases and conditions of the eye	$15 copay per visit
Annual glaucoma screening	$0 copay per visit
Annual eyewear benefit	Up to $150 allowance per calendar year
What You Should Know	You must use a participating vision care provider (EyeMed Vision Care) to receive the covered Routine Eye Exam benefit. You must purchase your glasses (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. Only one purchase is allowed per calendar year up to the benefit amount; any unused amount after the single purchase will expire and cannot be applied toward another purchase during the calendar year. A referral may be required from your PCP before you receive a diagnostic eye exam. Your PCP will provide this referral if needed.

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

Prescription Drug Benefits	Please see the Plan Highlights in your enrollment kit for additional information.

Additional Benefits	
Acupuncture	
Acupuncture services	$15 copay per visit
What You Should Know	Medicare covers up to 12 visits in 90 days for members with chronic low back pain. 8 additional visits covered for those demonstrating an improvement. No more than 20 visits administered annually. A referral may be required from your PCP before you receive these services. Your PCP will provide this referral if needed. Additional acupuncture services are eligible for reimbursement under the annual Wellness Allowance benefit. See additional details under "Wellness Programs."
Chiropractic Care	
Manual manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position)	$15 copay per visit
What You Should Know	Prior authorization may be required. A referral may be required from your PCP before you receive these services. Your PCP will provide this referral if needed.
Foot Care (podiatry services)	
Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions	$15 copay per visit
What You Should Know	A referral may be required from your PCP before you receive these services. Your PCP will provide this referral if needed.
Home Health Services	
Home health agency care	You pay nothing
Home infusion therapy	You pay nothing
What You Should Know	Prior authorization may be required. A referral may be required from your PCP before you receive home health agency care. Your PCP will provide this referral if needed.
Hospice	
	Benefit provided by Medicare
What You Should Know	You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.
Medical Equipment/Supplies	
Durable medical equipment (e.g., wheelchairs, oxygen)	You pay nothing
Prosthetic devices (e.g., braces, artificial limbs, etc.)	You pay nothing

Additional Benefits	
What You Should Know	Additional items covered by the plan: bathroom safety equipment for members who have a functional impairment when having the item will improve safety: • Raised toilet seat: 1 per member per lifetime • Bathroom grab bars: 2 per member per lifetime • Tub seat: 1 per member per lifetime Prior authorization may be required.
Wig allowance (for hair loss due to cancer treatment)	$350 per year
Diabetes services and supplies	You pay nothing
What You Should Know	Includes diabetes monitoring supplies, diabetes self-management training, and therapeutic shoes or inserts. Copay may apply if you receive other medical services during the same office visit. Coverage for blood glucose monitors and blood glucose tests strips is limited to the Accu-Chek products manufactured by Roche Diabetes Care, Inc. Please note that there is no preferred brand for lancets. Coverage for therapeutic Continuous Glucose Monitors (CGMs) is limited to Dexcom and FreeStyle Libre products that are considered Durable Medical Equipment (DME) by Medicare. Prior authorization is required for CGMs. 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.
Outpatient Substance Use Disorder Services	
Group or individual therapy visit	$15 copay per visit
Renal Dialysis	
	You pay nothing
Telehealth/Telemedicine Services	
	Medicare-covered services plus additional telehealth services including PCP services, specialist services, and more. $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.
Wellness Programs	
Weight Management program	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.
Wellness Allowance	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. Additional programs and items include alternative therapies, massage therapy, home fitness equipment and fitness tracking devices and heart rate monitors (limit of one per year).

Questions
Visit us at **www.thpmp.org, or** call **1-800-936-1902 (TTY: 711)**.

TUFTS Health Plan
1 Wellness Way
Canton, MA 02021