TUFTS Health Plan

a Point32Health company

Plan Highlights

Employer Group:
Tufts Medicare Preferred HMO Prime Rx

2025 Partial List of Benefit Allowances and Member Cost Sharing

Effective January 1, 2025–December 31, 2025. Please refer to the 2025 Employer Group HMO Prime Summary of Benefits booklet for further information.

Premiums	
Plan Premium	See your employer for premium amount.
Service Area	
Counties of Residence	Barnstable, Bristol, Essex, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, Worcester
Copays	
Primary Care Physician (PCP) Office Visits	$10 per visit, except $0 copay for annual physical and annual wellness visit
Specialist Office Visits	$15 per visit
Emergency Room	$50 per visit (waived if admitted within one day for the same condition)
Annual Routine Eye Exam	$15 per visit
Outpatient Services/Surgery	$50 per day
Ambulance Services	$50 copay for Medicare-covered ambulance benefits per day
Outpatient Rehabilitation Services	$15 copay per visit for Medicare-covered occupational, physical, and speech/language therapies. Prior authorization may be required.
Acute Inpatient Hospital Deductible (Note: Deductible applies to inpatient hospital admissions and does not apply to inpatient rehab or mental health admissions)	$300 per calendar year
Allowances	
Annual Eyewear Benefit	$150 per year towards eyewear at an EyeMed Vision Care participating provider, or $90 per year at non-participating providers
Annual Wellness Allowance	$150 per year toward fitness club membership, instructional fitness classes, nutritional counseling, acupuncture, and/or wellness programs such as memory fitness activities
Hearing Aids	Up to $500 toward purchase or repair every three (3) years
Weight Management Programs	$150 per year towards program fees for weight loss programs such as WeightWatchers or a hospital-based weight loss program
Out-Of-Pocket Maximum	
$3,400 per calendar year excluding plan premiums and prescription drug copays	

Prescription Drug Coverage

NOTE: See Comprehensive Formulary for limitations and exclusions.

No annual dollar limit on prescriptions.

Deductible Stage

There is a $590 Medicare Part D deductible which is satisfied by your copays and the Wrap coverage.* See cost share under the Initial Coverage Stage below.

Initial Coverage Stage

You stay in this stage until your year-to-date "total drug costs" (your payments plus payments by the Part D plan and Wrap plan) total $2,000. During this stage:

- You pay the applicable copay based on the tier of drug that you obtain.
- Tufts Medicare Preferred HMO plan will pay for 65% of the cost of the drug.
- The Wrap will pay the balance of the cost after your copay up to 25% of the cost of the drug.

You pay the following copays:

Retail Pharmacy	Tier 1	Tier 2	Vaccines	Tier 3
30-day supply	$10	$25	$0	$50 (Insulin: $35)
60-day supply	$20	$50	N/A	$100 (Insulin: $70)
90-day supply	$30	$75	N/A	$150 (Insulin: $105)
Mail-Order	**Tier 1**	**Tier 2**	**Vaccines**	**Tier 3**
30-day supply	$7	$17	N/A	$33
60-day supply	$14	$33	N/A	$67
90-day supply	$20	$50	N/A	$100

Catastrophic Coverage Stage

After your annual out-of-pocket costs reach $2,000, you pay nothing. During this payment stage, the plan pays the full cost for your covered Part D drugs.

*In 2025, Tufts Health Plan will include Wrap coverage in conjunction with your Part D drug coverage. Depending on which benefit stage you are in, the Wrap covers a portion of the cost of the drug. This Wrap is additional coverage to your plan and is offered through Tufts Insurance Company. Please refer to the table above for how the Wrap works in the different stages.

Tufts Health Plan is an HMO plan with a Medicare contract. Enrollment in Tufts Health Plan depends on contract renewal. Benefits eligibility requirements must be met. Not all may qualify. This information is not a complete description of benefits. Call 1-800-488-0229 (TTY: 711) for more information. 8 a.m.–8 p.m., 7 days a week (Mon.–Fri. from Apr. 1–Sept. 30). 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). H2256_2025_27_M