

2027 Benefit Changes

Tufts Medicare Preferred HMO

The following benefit changes apply to Tufts Medicare Preferred HMO members and are **effective for dates of service on or after Jan. 1, 2027**, upon the plan's effective or renewal date:

Summary of Benefit Changes

The following changes may not apply to all plans.

- **Smart Saver Rx HMO plan will be split up into three segments as follows:**
 - Segment 1: includes Hampden, Hampshire, Middlesex, and Worcester Counties
 - Segment 2: includes Bristol, Essex, Norfolk, Plymouth, and Suffolk Counties
 - Segment 3: includes Barnstable County
 - Plan name remains **Tufts Medicare Preferred HMO Smart Saver Rx (HMO)** in all segments.
 - Premium remains \$0 in all three segments; however, benefits vary by segment as summarized below.
- **Medical changes to Smart Saver Rx HMO plan** (*please note that only benefits that changed for at least one segment are listed*):

	2026 Smart Saver	2027 Smart Saver Segment 1	2027 Smart Saver Segment 2	2027 Smart Saver Segment 3
Service Area	Barnstable, Bristol, Essex, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, Worcester	Hampden, Hampshire, Middlesex, Worcester	Bristol, Essex, Norfolk, Plymouth, Suffolk	Barnstable
Premium	\$0	\$0	\$0	\$0
Benefit/ Cost Share Changes				
Maximum Out of Pocket (MOOP)	\$6,400	\$7,150	\$7,150	\$9,850
Ambulance services	\$350	\$375	\$375	\$375
Cardiac rehabilitation services	\$0	\$20	\$20	\$20
Supplemental dental benefit:				
Annual limit	\$1,500	\$1,000	\$750	\$500
Class 1 preventive services	\$0	\$0	\$0	\$0
Class 2 basic services	20%	50%	50%	50%
Class 3 major services	50%	50%	50%	50%
Durable medical equipment and related supplies				
Basic devices and items	20%	\$0	\$0	20%
Moderate complexity devices and items	20%	20%	20%	20%
Complex devices	20%	50%	50%	20%
Therapeutic shoes/inserts	20%	50%	50%	20%
Emergency care	\$130	\$130	\$130	\$115
Inpatient hospital care & rehabilitation (per day)	\$425 for days 1-6	\$459 for days 1-6	\$550 for days 1-5	\$490 for days 1-5
Inpatient services in a psychiatric hospital (per day)	\$370 for days 1-5	\$450 for days 1-5	\$550 for days 1-4	\$490 for days 1-4
Specialist office visit	\$50	\$60	\$70	\$60
Outpatient diagnostic radiology services (per day)	\$100 Ultrasound; \$200 Others	\$295 Ultrasound; \$350 Others	\$195 Ultrasound; \$350 Others	\$145 Ultrasound; \$350 Others
Outpatient hospital observation	\$370	\$370	\$450	\$450
Outpatient surgery services (per day):				
Hospital outpatient facilities (colonoscopies: \$0)	\$370	\$370	\$450	\$450
Ambulatory surgical centers (colonoscopies: \$0)	\$270	\$270	\$350	\$350
Over-the-Counter (OTC) for Medicare Items	\$75 per quarter	Not covered	Not covered	Not covered
Partial hospitalization services	\$0	\$55	\$55	\$55
Intensive outpatient services	\$0	\$55	\$55	\$55
Skilled nursing facility (SNF) care (per day)	\$0 for days 1-20; \$218 for days 21-100	\$0 for days 1-20; \$221 for days 21-100	\$0 for days 1-20; \$221 for days 21-100	\$0 for days 1-20; \$221 for days 21-100
Supervised exercise therapy for peripheral artery disease	\$0	\$15	\$15	\$15
Urgently needed care	\$50	\$50	\$50	\$40
Diagnostic eye exam	\$40	\$15	\$15	\$15
Diabetic retinopathy	\$15 or \$40	\$0	\$0	\$0
Routine eyewear allowance (per year)	\$250 (EyeMed) \$150 (non-EyeMed)	\$150 (any provider)	\$150 (any provider)	Not covered
Weight Management Programs (per year)	\$150	\$150	\$150	Not covered
Wellness Allowance (per year)	\$300	\$150	\$150	Not covered

- **Medical changes to other premium HMO plans** (please note that only benefits that changed for at least one plan are listed):

	Prime Rx+		Prime		Value		Basic	
	2026	2027	2026	2027	2026	2027	2026	2027
Premium by Service Area/Countries - Rx Plans								
Barnstable, Bristol, Middlesex, Norfolk & Plymouth	\$227	\$252	\$193	\$214	\$166	\$185	\$58	\$82
Essex & Suffolk	\$255	\$280	\$223	\$244	\$188	\$207	\$68	\$88
Hampden & Hampshire	\$132	\$158	\$116	\$138	\$93	\$108	\$47	\$65
Worcester	NA	NA	\$203	\$224	\$173	\$190	\$55	\$85
Premium by Service Area/Countries - No Rx Plans								
Barnstable, Bristol, Middlesex, Norfolk & Plymouth	NA	NA	\$153	\$163	\$123	\$133	NA	NA
Essex & Suffolk	NA	NA	\$176	\$186	\$143	\$153	\$48	\$58
Hampden & Hampshire	NA	NA	NA	NA	NA	NA	NA	NA
Worcester	NA	NA	\$172	\$182	\$132	\$142	\$40	\$50
Benefit/Cost Share Changes (Note: No Rx coverage is shown in parenthesis where different)								
Maximum Out of Pocket (MOOP)	\$3,850	\$3,850	\$3,850	\$3,850	\$3,850	\$4,200	\$3,850	\$4,500
Tufts Medicare Preferred Dental Option premium	\$38.50	\$38.50	\$38.50	\$38.50	\$38.00	\$41.50	\$38.00	\$41.50
DME: Over The Counter Bathroom Safety Items	10%	10%	10%	10%	10%	Not Covered (No Rx: 10%)	20%	Not Covered (No Rx: 20%)
Emergency care	\$110	\$130	\$110	\$130	\$125	\$130	\$125	\$130
Inpatient hospital care & rehabilitation (per day)	\$200 up to \$400	\$200 up to \$400	\$300 up to \$900	\$300 up to \$900	\$200 for days 1-5	\$300 for days 1-5	\$275 for days 1-5	\$350 for days 1-5
Medical nutrition therapy - additional 3 hours beyond Medicare coverage	Covered	Covered	Covered	Covered	Covered	Not Covered (No Rx covered)	Covered	Not Covered (No Rx covered)
Medicare Part B Insulin drugs (1-month supply)	\$0	\$35	\$0	\$35 (No Rx: \$0)	\$0	\$35 (No Rx: \$0)	\$35	\$35
Medicare Part B other drugs	0%	up to 20%	0%	up to 20% (No Rx: 0%)	0%	up to 20% (No Rx: 0%)	up to 20%	up to 20%
Specialist office visit	\$15	\$30	\$15	\$30 (No Rx: \$20)	\$25	\$35	\$40	\$45
Outpatient diagnostic radiology services (per day)	20% up to \$75	20% up to \$75	20% up to \$75	20% up to \$75	\$100	\$100	\$100 Ultrasound; \$250 Others	\$100 Ultrasound; \$350 Others (No Rx: \$250)
Outpatient hospital observation (per stay)	\$75	\$175	\$100	\$200	\$150	\$250	\$270	\$300
Outpatient surgery services (per day):								
Hospital outpatient facilities (colonoscopies: \$0)	\$75	\$175	\$100	\$200	\$150	\$250	\$270	\$300
Ambulatory surgical centers (colonoscopies: \$0)	\$75	\$75	\$100	\$100	\$150	\$150	\$170	\$170
Partial hospitalization services	\$0	\$55	\$0	\$55	\$0	\$55	\$0	\$55
Intensive outpatient services	\$0	\$55	\$0	\$55	\$0	\$55	\$0	\$55
Skilled nursing facility (SNF) care (per day)	\$20 for days 1-20; \$0 for days 21-100	\$0 for days 1-20; \$80 for days 21-44; \$0 for days 45-100	\$20 for days 1-20; \$80 for days 21-44; \$0 for days 45-100	\$0 for days 1-20; \$110 for days 21-44; \$0 for days 45-100	\$20 for days 1-20; \$120 for days 21-44; \$150 for days 21-44;	\$0 for days 1-20; \$150 for days 21-44; \$160 for days 21-44;	\$20 for days 1-20; \$160 for days 21-44; \$170 for days 21-44;	\$0 for days 1-20; \$170 for days 21-44; \$170 for days 21-44;
Diagnostic eye exam	\$15	\$15	\$15	\$15	\$25	\$15	\$40	\$15
Diabetic retinopathy	\$15	\$0	\$15	\$0	\$15 or \$25 per visit	\$0	\$15 or \$40 per visit	\$0
Routine eyewear allowance	\$150 (EyeMed) \$90 (non-EyeMed)	\$150 (any provider)	\$150 (EyeMed) \$90 (non-EyeMed)	\$150 (any provider)	\$150 (EyeMed) \$90 (non-EyeMed)	\$150 (any provider)	\$150 (EyeMed) \$90 (non-EyeMed)	\$150 (any provider)
Wigs allowance (per year)	\$500	\$500	\$500	\$500	\$500	Not Covered (No Rx covered)	\$500	Not Covered (No Rx covered)

- **Changes to Part D coverage** (all Rx plans, except where noted otherwise):
 - Member liability cap will be \$2,400 per year; members will have no cost share for covered Part D drugs after they reach this limit. However, cost share will continue to apply to excluded drugs covered under our enhanced benefit.
 - Annual Part D deductible will apply to non-insulin drugs on Tier 3, Tier 4, and Tier 5 as follows:
 - \$700 for Smart Saver Rx plans
 - \$200 for Basic Rx and Value Rx plans
 - Deductible does not apply to drugs on Tier 1, Tier 2, and Tier 6 (Vaccine).
 - Coinsurance for Tier 3 drugs are as follows:
 - Basic Rx Worcester County: 17%
 - Basic Rx Other Counties: 20% (no change)
 - Coinsurance for Tier 5 drugs are as follows:
 - Basic Rx: 31% (Worcester County); 30% (Other Counties)
 - Value Rx: 26% (Worcester County); 27% (Other Counties)
 - Prime Rx: 33% (Worcester County); 32% (Other Counties)
 - Members may receive up to a [100-day supply](#) of Tier 1 drugs included on the formulary.

Please note that this is only a summary of benefit changes. Before services are rendered, providers are reminded to check member benefits and cost-share amounts using Tufts Health Plan's [secure Provider portal](#) or other self-service tools, even for members seen on a regular basis.

Tufts Medicare Preferred PPO

The following benefit changes apply to Tufts Medicare Preferred PPO members and are **effective for dates of service on or after Jan. 1, 2027**, upon the plan's effective or renewal date:

Summary of Benefit Changes

- **Existing Tufts Medicare Preferred PPO Rx plan with three premium segments will not be offered in 2027.** Members will not be automatically enrolled in the replacement PPO Rx plan described below. Per regulatory guidelines, members will be notified to enroll in other plans of their choice during open enrollment.
- **A new premium PPO Rx plan will be launched**, with the following key medical benefits (in-network except otherwise specified):
 - Plan name: Tufts Medicare Preferred Rx (PPO).
 - Monthly premiums: \$200 (all counties).
 - Annual maximum out of pocket (MOOP) cost: \$7,150 for in-network services and \$10,750 for combined in-network and out-of-network services.
 - Copayment for PCP office visit: \$0 (in-network), \$80 per visit (out-of-network).
 - Copayment for specialist office visit: \$75 per visit (in-network), \$100 per visit (out-of-network).
 - Copayment for emergency services: \$130 per visit.
 - Cost share for Durable medical equipment and related supplies:
 - 0% for basic devices and items such as low-cost canes, crutches, walkers, etc.
 - 20% coinsurance for moderate complexity devices and items such as oxygen equipment and supplies, light weight non-standard wheelchairs, etc.
 - 50% coinsurance for complex devices such as powered non-standard wheelchairs, powered scooters, specialized beds, etc.
 - Cost share for therapeutic shoes or inserts: 50% coinsurance.
 - Copayment for inpatient hospital care: \$550 per day for days 1-5 (\$550 per day for days 1-4 for services in a psychiatric hospital).
 - Copayment for outpatient hospital services, including outpatient surgery: \$450 per day (\$0 for colonoscopies).
 - Copayment for outpatient surgery at ambulatory surgical center (ASC): \$350 per day (\$0 for colonoscopies).
 - Copayment for outpatient diagnostic radiology services: \$300 per day (\$100 for ultrasounds).
 - Copayment for outpatient labs \$0; tests and x-rays \$30 per day.
 - Copayment for skilled nursing facility (SNF) care: \$0 per day (days 1-20) and \$221 per day (days 21-100).
 - Copayment for cardiac rehabilitation services: \$20 per visit.
 - Copayment for Partial hospitalization services and Intensive outpatient services: \$55 per visit.
 - Copayment for Pulmonary rehabilitation services: \$0.
 - Copayment for urgent care services: \$50 per visit.
 - Copayment for ambulance services: \$375 per one-way trip.
 - Coinsurance for most out of network services: 45% (50% for inpatient services, outpatient surgery services, DME and a few other services).

- **Tufts Medicare Preferred Rx (PPO) will not include the following supplemental benefits:**
 - Supplemental dental benefit.
 - Over-the-counter (OTC) benefit.
 - Meals post-hospitalization/rehabilitation.
 - Non-emergency transportation.
 - Prescription hearing aid benefit.
 - Eyewear allowance.
 - Annual Wellness Allowance
- **Tufts Medicare Preferred Rx (PPO) will include Part D coverage as follows:**
 - Member liability cap of \$2,400 per year; members will have no cost share for covered Part D drugs after they reach this limit. However, cost share will continue to apply to excluded drugs covered under our enhanced benefit.
 - An annual deductible of \$700 will apply to non-insulin drugs on Tier 3, Tier 4, and Tier 5. No deductible for Tier 1, Tier 2, and Tier 6 (Vaccine) drugs.
 - Tier 1 drugs retail copay for one month supply \$0 (preferred) and \$5 (standard).
 - Tier 2 drugs retail copay for one month supply \$2 (preferred) and \$12 (standard).
 - Tier 3, Tier 4, and Tier 5 drugs coinsurance of 20%, 25%, and 25%, respectively.
 - Enhanced coverage for Medicare excluded drugs limited to select erectile dysfunction drugs (Tadalafil and Sildenafil Citrate).
 - Members may receive up to a [100-day supply](#) of Tier 1 drugs included on the formulary.

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