

MEDICARE ADVANTAGE (HMO) PLANS | 2019



Plan Comparison Chart

Includes medical and
prescription drug (Rx)
benefit information



PLAN COMPARISON CHART

HMO Saver or Basic plans may be a good fit if you:

- Are relatively healthy or don't plan to visit the doctor often
- Want a \$0 or low monthly premium with capped out-of-pocket costs and more health benefits than Original Medicare
- Want a plan that includes additional benefits like eyewear, dental, and wellness reimbursement

Monthly Plan Premium by County	HMO Saver Rx	HMO Basic No Rx ¹	HMO Basic Rx
Barnstable, Bristol, Middlesex, Norfolk & Plymouth	\$0	Not Offered	\$40
Essex & Suffolk	\$0	\$28	\$55
Hampden & Hampshire	\$0	Not Offered	\$23
Worcester	\$0	\$20	\$42

Medical Coverage

Plan Medical Costs	HMO Saver Rx	HMO Basic No Rx ¹	HMO Basic Rx
Medical Deductibles	No medical deductible		
Annual Out-of-Pocket Maximum ²	\$6,000	\$3,400	\$3,400

Copays	HMO Saver Rx	HMO Basic No Rx ¹	HMO Basic Rx
Doctor Office Visits			
Primary Care Physician (PCP)	\$10	\$10	
Specialist	\$45	\$40	
Preventive Care			
Annual Physical	\$0	\$0	
Cancer Screening (Colorectal, Prostate, Breast)	\$0 per service	\$0 per service	
Vision and Hearing			
Annual Routine Vision Exam	\$45	\$40	
Annual Eyewear Benefit	\$150 per year toward eyewear at an EyeMed Vision Care participating provider or \$90 per year at non-participating providers.		
Annual Routine Hearing Exam	\$45	\$40	
Hearing Aid Benefit (2 hearing aids per year, 1 per ear)	\$250 Standard level \$475 Superior level \$650 Advanced level \$850 Advanced Plus level	\$250 Standard level \$475 Superior level \$650 Advanced level \$850 Advanced Plus level	
Outpatient and Lab Services			
Outpatient Services / Surgery	\$350 per day	\$250 per day	
Physical Therapy ³	\$40	\$30	
Occupational Therapy ³	\$40	\$30	
Speech Therapy	\$40	\$30	
Mental Health and Substance Abuse Services	\$25	\$25	
Laboratory Services, X-rays, Diagnostic Procedures	\$20	\$10	
Diagnostic Radiology Services	\$325 per day	\$250 per day	
Emergency Services			
Emergency Room	\$90	\$110	
Urgent Care	\$10-\$45	\$10-\$40	
Ambulance Services	\$325 per day	\$275 per day	

Copays	HMO Saver Rx	HMO Basic No Rx ¹	HMO Basic Rx
Inpatient Care Inpatient Hospital Coverage	Days 1-5: \$350 per day, \$0 per day after day 5	Days 1-5: \$275 per day, \$0 per day after day 5	
Additional Benefits Wellness Allowance	\$250 per year toward fitness club membership, instructional fitness classes, nutritional counseling, acupuncture, or wellness programs such as memory fitness activities	\$150 per year toward fitness club membership, instructional fitness classes, nutritional counseling, acupuncture, or wellness programs such as memory fitness activities	
Weight Management Programs	\$150 annual reimbursement toward program fees for weight loss programs such as Weight Watchers, Jenny Craig, or hospital-based weight loss programs		
Preventive Dental Allowance	\$150 per year toward preventive dental services such as cleanings and X-rays		

Prescription Drug (Rx) Coverage

Plan Drug (Rx) Costs	HMO Saver Rx		HMO Basic Rx	
Deductible	\$0 for Tiers 1-2; \$400 for Tiers 3-5		\$0 for Tiers 1-2; \$350 for Tiers 3-5	
Copays	Retail 30-day supply	Mail Order 90-day supply	Retail 30-day supply	Mail Order 90-day supply
Tier 1: Preferred Generic	\$4	\$8	\$4	\$8
Tier 2: Generic	\$8	\$16	\$8	\$16
Tier 3: Preferred Brand	\$45	\$90	\$45	\$90
Tier 4: Non-Preferred Drug	\$100	\$300	\$100	\$300
Tier 5: Specialty Tier	25%	N/A	26%	N/A
Coverage Gap Stage: After your total prescription drug costs reach \$3,820, and until your payments reach \$5,100, you pay:	<ul style="list-style-type: none"> • 37% for Part D generic drugs • 25% of costs for Part D brand drugs plus a portion of the dispensing fee⁴ 			
Catastrophic Coverage Stage: After the coverage gap, when your payments for the year are greater than \$5,100, you pay the greater of:	<ul style="list-style-type: none"> • 5% per prescription or • \$3.40 per prescription for Part D generic drugs • \$8.50 per prescription for Part D brand drugs 			

This is a quick reference guide. For complete benefit information, see the Summary of Benefits booklet located on our website at www.thpmp.org/documents.

¹Not available in all counties.

²Comprises all your medical copays/coinsurance—your out-of-pocket costs will never exceed this amount.

³You pay \$0 for a post-outpatient surgical procedure physical therapy or occupational therapy consultation of up to 15 minutes, prior to discharge.

⁴The amount discounted by the manufacturer in the Coverage Gap counts toward 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: costs may differ if you receive your benefits from a current or former employer.

HMO Value and Prime plans may be a good fit if you:

- Visit your PCP or specialists more frequently and/or manage a condition like diabetes or high blood pressure
- Are looking for a low out-of-pocket maximum and lower copayments for services you use most often
- Are looking for prescription drug coverage with low copayments and affordable deductibles

Monthly Plan Premium by County	HMO Value No Rx ¹	HMO Value Rx	HMO Prime No Rx ¹	HMO Prime Rx	HMO Prime Rx Plus ¹
Barnstable, Bristol, Middlesex, Norfolk & Plymouth	\$103	\$131	\$133	\$165	\$199
Essex & Suffolk	\$123	\$151	\$156	\$188	\$220
Hampden & Hampshire	Not Offered	\$54	Not Offered	\$79	\$99
Worcester	\$112	\$146	\$152	\$185	Not Offered

Medical Coverage

Plan Medical Costs	HMO Value No Rx ¹	HMO Value Rx	HMO Prime No Rx ¹	HMO Prime Rx	HMO Prime Rx Plus ¹
Medical Deductibles	No medical deductible				
Annual Out-of-Pocket Maximum ²	\$3,400				

Co-Pays	HMO Value No Rx ¹	HMO Value Rx	HMO Prime No Rx ¹	HMO Prime Rx	HMO Prime Rx Plus ¹
Doctor Office Visits					
Primary Care Physician (PCP)	\$10			\$10	
Specialist	\$25			\$15	
Preventive Care					
Annual Physical	\$0			\$0	
Cancer Screening (Colorectal, Prostate, Breast)	\$0 per service			\$0 per service	
Vision and Hearing					
Annual Routine Vision Exam	\$25			\$15	
Annual Eyewear Benefit	\$150 per year toward eyewear at an EyeMed Vision Care participating provider or \$90 per year at non-participating providers.				
Annual Routine Hearing Exam	\$25			\$15	
Hearing Aid Benefit (2 hearing aids per year, 1 per ear)	\$250 Standard level \$475 Superior level \$650 Advanced level \$850 Advanced Plus level			\$250 Standard level \$475 Superior level \$650 Advanced level \$850 Advanced Plus level	
Outpatient and Lab Services					
Outpatient Services / Surgery	\$150 per day		\$100 per day		\$75 per day
Physical Therapy ³	\$20			\$15	
Occupational Therapy ³	\$20			\$15	
Speech Therapy	\$20			\$15	
Mental Health and Substance Abuse Services	\$25			\$15	
Laboratory Services, X-rays, Diagnostic Procedures	\$5			\$0	
Diagnostic Radiology Services	\$100 per day			20% up to \$75 per day	

Copays	HMO Value No Rx ¹	HMO Value Rx	HMO Prime No Rx ¹	HMO Prime Rx	HMO Prime Rx Plus ¹
Emergency Services					
Emergency Room	\$110		\$110		
Urgent Care	\$10-\$25		\$10-\$15		
Ambulance Services	\$225 per day		\$125 per day		\$90 per day
Inpatient Care					
Inpatient Hospital Coverage	Days 1-5: \$200 per day, \$0 per day after day 5		\$300 per stay; you will not pay more than \$900 per year		\$200 per stay; you will not pay more than \$400 per year
Additional Benefits	\$150 per year toward fitness club membership, instructional fitness classes, nutritional counseling, acupuncture, or wellness programs such as memory fitness activities				
Wellness Allowance					
Weight Management Programs	\$150 annual reimbursement toward program fees for weight loss programs such as Weight Watchers, Jenny Craig, or hospital-based weight loss programs				

Prescription Drug (Rx) Coverage

Plan Drug (Rx) Costs	HMO Value Rx		HMO Prime Rx		HMO Prime Rx Plus ¹	
Deductible	\$0 for Tiers 1-2; \$300 for Tiers 3-5		No deductible		No deductible	
Copays	Retail 30-day supply	Mail Order 90-day supply	Retail 30-day supply	Mail Order 90-day supply	Retail 30-day supply	Mail Order 90-day supply
Tier 1: Preferred Generic	\$4	\$8	\$4	\$8	\$2	\$4
Tier 2: Generic	\$8	\$16	\$8	\$16	\$4	\$8
Tier 3: Preferred Brand	\$45	\$90	\$45	\$90	\$30	\$60
Tier 4: Non-Preferred Drug	\$100	\$300	\$100	\$300	\$80	\$240
Tier 5: Specialty Tier	27%	N/A	33%	N/A	33%	N/A
Coverage Gap Stage: After your total prescription drug costs reach \$3,820, and until your payments reach \$5,100, you pay:	<ul style="list-style-type: none"> • 37% for Part D generic drugs • 25% of costs for Part D brand drugs plus a portion of the dispensing fee⁴ 				<ul style="list-style-type: none"> • Tier 1 copayments for generic drugs on Tier 1 • Tier 2 copayments for generic drugs on Tier 2 • 37% for all other generic drugs • 25% of costs for Part D brand drugs plus a portion of the dispensing fee⁴ 	
Catastrophic Coverage Stage: After the coverage gap, when your payments for the year are greater than \$5,100, you pay the greater of:	<ul style="list-style-type: none"> • 5% per prescription or • \$3.40 per prescription for Part D generic drugs • \$8.50 per prescription for Part D brand drugs 					

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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. Tufts Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Tufts Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Tufts Health Plan at <1-800-701-9000 (TTY: 711).>

If you believe that Tufts Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Tufts Health Plan, Attention:

Civil Rights Coordinator, Legal Dept.
705 Mount Auburn St.
Watertown, MA 02472
Phone: 1-888-880-8699 ext. 48000 (TTY: 711)
Fax: 1-617-972-9048
Email: OCRCoordinator@tufts-health.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Tufts Health Plan Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019 (TDD: 1-800-537-7697)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

thpmp.org | 1-800-701-9000 (TTY: 711)

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-701-9000 (TTY: 711).

Arabic: ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-701-9000 (رقم هاتف الصم والبكم: 711).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-701-9000 (TTY: 711)。

Farsi: توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. 1-800-701-9000 (TTY: 711) فراموش نکنید.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-701-9000 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-701-9000 (TTY: 711).

Greek: ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-701-9000 (TTY: 711).

Gujarati: સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-701-9000 (TTY: 711).

Haitian Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-701-9000 (TTY: 711).

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-701-9000 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-701-9000 (TTY: 711) まで、お電話にてご連絡ください。

Khmer (Cambodian): ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្អល គឺអាចមានសំរាប់បំរើអ្នក។ ថ្ងៃ ទី 1-800-701-9000 (TTY: 711)

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-701-9000 (TTY: 711) 번으로 전화해 주십시오.

Laotian: ໂປດຊາຍ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-701-9000 (TTY: 711).

Navajo: Díí baa akó nínízin: Díí saad bee yánílti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę, t'áá jiik'eh, éí ná hóló, kojí' hódílnih 1-800-701-9000 (TTY: 711).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-701-9000 (TTY: 711).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-701-9000 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-701-9000 (TTY: 711).

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-701-9000 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-701-9000 (TTY: 711).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-701-9000 (TTY: 711).



QUESTIONS?

Call 1-800-890-6600 // TTY: 711

Representatives are available Monday – Friday, 8 a.m. – 8 p.m. (From October 1 – March 31, 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.

VISIT: www.thpmp.org

KNOW WHICH PLAN YOU WOULD LIKE?

Write it here for easy reference during the enrollment process.

Plan Name: _____

Monthly Premium: _____ PCP Name: _____

You will also need to have your Medicare Number (located on your Medicare ID card)

You can enroll at: www.thpmp.org or call 1-800-890-6600

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 1-800-488-0229 (TTY: 711) for more information.

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