TUFTS MEDICARE PREFERRED HMO PLANS | 2018

# HMO Plan Comparison Chart

To help you understand some of the costs associated with Tufts Medicare Preferred HMO's more commonly used services, we have created this handy reference guide.

There are two sets of charts you can refer to:

- Medical Coverage
- Prescription Drug (Rx) Coverage

# HMO PLAN COMPARISON CHART | 2018

This is a quick reference guide to some of the more commonly used services. For more complete plan benefit information, review our Summary of Benefits booklets located in the "Documents" section on our website, **thpmp.org/documents**.

| Monthly Plan Premium[1] by County | HMO Saver Rx[2] | HMO Basic No Rx[2] | HMO Basic Rx | HMO Value No Rx | HMO Value Rx | HMO Prime No Rx | HMO Prime Rx | HMO Prime Rx Plus[2] |
|---|---|---|---|---|---|---|---|---|
| **Barnstable, Bristol, Middlesex, Norfolk & Plymouth** | $0 | Not Offered | $46 | $103 | $132 | $133 | $166 | $200 |
| **Essex & Suffolk** | $0 | $38 | $66 | $123 | $152 | $156 | $189 | $221 |
| **Hampden & Hampshire** | Not Offered | Not Offered | $24 | $41 | $70 | $67 | $100 | $132 |
| **Worcester** | $0 | $40 | $68 | $112 | $147 | $152 | $186 | Not Offered |

## Medical Coverage

| Plan Medical Costs | HMO Saver Rx[2] | HMO Basic No Rx[2] | HMO Basic Rx | HMO Value No Rx | HMO Value Rx | HMO Prime No Rx | HMO Prime Rx | HMO Prime Rx Plus[2] |
|---|---|---|---|---|---|---|---|---|
| **Medical Deductibles** | No medical deductible | | | No medical deductible | | | | |
| **Annual Out-of-Pocket Maximum[3]** | $4,500 | $3,400 | $3,400 | $3,400 | $3,400 | $3,400 | $3,400 | $3,400 |

| Co-Pays | HMO Saver Rx[2] | HMO Basic No Rx[2] | HMO Basic Rx | HMO Value No Rx | HMO Value Rx | HMO Prime No Rx | HMO Prime Rx | HMO Prime Rx Plus[2] |
|---|---|---|---|---|---|---|---|---|
| **Doctor Office Visits** | | | | | | | | |
| **Primary Care Physician (PCP)** | $20 per visit | $10 per visit | | $10 per visit | | $10 per visit | | |
| **Specialist** | $45 per visit | $40 per visit | | $25 per visit | | $15 per visit | | |
| **Preventive Care** | | | | | | | | |
| **Annual Physical** | $0 per visit | $0 per visit | | $0 per visit | | $0 per visit | | |
| **Cancer Screening (Colorectal, Prostate, Breast)** | $0 per visit | $0 per visit | | $0 per visit | | $0 per visit | | |
| **Vision and Hearing** | | | | | | | | |
| **Annual Routine Vision Exam** | $45 per visit | $40 per visit | | $25 per visit | | $15 per visit | | |
| **Annual Eyewear Benefit** | $150 per year toward eyewear at an EyeMed Vision Care participating provider or $90 per year at non-participating providers. | | | $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 per visit | $40 per visit | | $25 per visit | | $15 per visit | | |
| **Hearing Aid Allowance** | Not covered | Not covered | | Hearing aids are covered up to an allowance of $500 every 3 years | | Hearing aids are covered up to an allowance of $500 every 3 years | | |
| **Outpatient and Lab Services** | | | | | | | | |
| **Outpatient Services / Surgery** | $350 per day | $250 per day | | $150 per day | | $100 per day | | $75 per day |
| **Physical Therapy[4]** | $40 per visit | $30 per visit | | $20 per visit | | $15 per visit | | |
| **Occupational Therapy[4]** | $40 per visit | $30 per visit | | $20 per visit | | $15 per visit | | |
| **Speech Therapy** | $40 per visit | $30 per visit | | $20 per visit | | $15 per visit | | |
| **Laboratory Services, X-rays, Diagnostic Procedures** | $10 per service per day | $10 per service per day | | $5 per service per day | | $0 per service per day | | |
| **Diagnostic Radiology Services** | $300 per day | $250 per day | | $100 per day | | 20% up to $75 per day | | |
| **Emergency Services** | | | | | | | | |
| **Emergency Room** | $80 per visit | $100 per visit | | $100 per visit | | $100 per visit | | |
| **Urgently Needed Care** | $20-$45 per visit | $10-$40 per visit | | $10-$25 per visit | | $10-$15 per visit | | |
| **Ambulance Services** | $300 per day | $275 per day | | $225 per day | | $125 per day | | $90 per day |

[1]You must continue to pay your Medicare Part B premium.
[2]Not available in all counties.
[3]Comprised of all your medical copays/coinsurance—your out-of-pocket costs will never exceed this amount.

[4]You pay $0 for a post-outpatient surgical procedure physical therapy or occupational therapy consultation of up to 15 minutes, prior to discharge.
Please note: costs may differ if you receive your benefits from a current or former employer.

## Medical Coverage cont.

| Copays | HMO Saver Rx[2] | HMO Basic No Rx[2] | 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, iDiet, or hospital-based weight loss programs | | |

| Copays | HMO Value No Rx | HMO Value Rx | HMO Prime No Rx | HMO Prime Rx | HMO Prime Rx Plus[2] |
|---|---|---|---|---|---|
| **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** | | | | | |
| **Wellness Allowance** | $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, iDiet, or hospital-based weight loss programs | | | | |

## Prescription Drug (Rx) Coverage

| Plan Drug (Rx) Costs | HMO Saver Rx[2] | | 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** | $6 | $12 | $4 | $8 |
| **Tier 2: Generic** | $12 | $24 | $8 | $16 |
| **Tier 3: Preferred Brand** | $47 | $94 | $47 | $94 |
| **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 $3,750, and until your payments reach $5,000, you pay: | • 44% for Part D generic drugs<br>• 35% of costs for Part D brand drugs plus a portion of the dispensing fee[5] | | | |
| **Catastrophic Coverage Stage:** After the coverage gap, when your payments for the year are greater than $5,000, you pay the greater of: | • 5% per prescription<br>or<br>• $3.35 per prescription for Part D generic drugs<br>• $8.35 per prescription for Part D brand drugs | | | |

| Plan Drug (Rx) Costs | HMO Value Rx | | HMO Prime Rx | | HMO Prime Rx Plus[2] | |
|---|---|---|---|---|---|---|
| **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** | $47 | $94 | $47 | $94 | $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** | • 44% for Part D generic drugs<br>• 35% of costs for Part D brand drugs plus a portion of the dispensing fee[5] | | | | • Tier 1 copayments for generic drugs on Tier 1<br>• Tier 2 copayments for generic drugs on Tier 2<br>• 44% for all other generic drugs<br>• 35% of costs for Part D brand drugs plus a portion of the dispensing fee[5] | |
| **Catastrophic Coverage Stage** | • 5% per prescription<br>or<br>• $3.35 per prescription for Part D generic drugs<br>• $8.35 per prescription for Part D brand drugs | | | | | |

[2]Not available in all counties.

[5]The 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.

**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 number—711 or 1-800-439-2370. Español: 866-930-9252)
Fax: 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, 800-537-7697 (TDD)

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

thpmp.org | 1-800-701-9000

**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) فراهم می باشد. با تماس بگیرید.

**French:** ATTENTION: Si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez le 1-800-701-9000 (ATS : 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 ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 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:** ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-701-9000 (TTY: 711).

**Navajo:** Díí baa akó nínízin: Díí saad bee yáníłti’go **Diné Bizaad**, saad bee áká’ánída’áwo’dę́ę́’, t’áá jiik’eh, éí ná hóló, koji’ hódíílnih 1800-701-9000 (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 (телетайп: 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 1-844-455-3299 // TTY 711

Representatives are available Monday – Friday, 8 a.m. – 8 p.m. (From October 1 – February 14, 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 US AT: thpmp.org

## KNOW WHICH PLAN YOU WOULD LIKE?

**Write it here for easy reference during the enrollment process.**

Tufts Medicare Preferred HMO Plan Name: ____________________

Monthly Premium: __________ PCP Name: ____________________

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

**You can enroll at: thpmp.org or call 1-844-455-3299**

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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. Contact the plan for more information.

Limitations, copayments, and restrictions may apply. Benefits, premiums, and/or copayments and coinsurance may change on January 1 of each year. The Formulary, pharmacy network, and/or provide network may change at any time. You will receive notice when necessary.

H2256_2018_103 Accepted

TUFTS Health Plan