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TUFTS HEALTH PLAN SENIOR CARE OPTIONS (HMO SNP) | 2016

Summary of Benefits

Effective January 1, 2016–December 31, 2016

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SUMMARY OF BENEFITS

January 1, 2016 – December 31, 2016

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

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 Health Plan Senior Care Options (HMO SNP)).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what Tufts Health Plan Senior Care Options (HMO SNP) 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 <http://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 <http://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.

Sections in this booklet

- Things to Know About Tufts Health Plan Senior Care Options (HMO SNP)
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

This document is available in other formats such as Braille and large print.

This document may be available in a non-English language. For additional information, call us at 1-855-670-5934.

Esta información está disponible gratis en otros idiomas. Para obtener información adicional llame nuestro Servicios para Miembros al 1-855-670-5934.

Things to Know About Tufts Health Plan Senior Care Options (HMO SNP)

Hours of operation

- From October 1 to February 14, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern time.
- From February 15 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern time.

Tufts Health Plan Senior Care Options (HMO SNP) phone numbers and website

- If you are a member of this plan, call toll-free 1-855-670-5934.
- If you are not a member of this plan, call toll-free 1-855-670-5935.
- Our website: thpmp.org/sco

Who can join?

To join Tufts Health Plan Senior Care Options (HMO SNP), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and MassHealth Standard (Medicaid), and live in our service area.

Our service area 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 Health Plan Senior Care Options (HMO SNP) has a network of doctors, hospitals, pharmacies, and other providers. If you use the 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 and pharmacy directory at our website (thpmp.org/sco).

Or, call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Like all Medicare health plans, 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 more in our plan than what you would in Original Medicare. For others, you may pay less.
- Our plan members also get *more than what is* covered by Original Medicare. Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover 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, thpmp.org/sco.
- Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

The amount you pay for drugs depends on the drug you are taking and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur after you meet your deductible: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

SUMMARY OF BENEFITS — January 1, 2016 - December 31, 2016
Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services

How much is the monthly premium?

\$0 per month.

How much is the deductible?

This plan does not have a deductible.

This plan does not have a deductible for chemotherapy and other drugs administered by your doctor's office (Part B drugs).

This plan does not have a deductible for Part D prescription drugs.

Is there any limit on how much I will pay for my covered services?

Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.

In this plan, you may pay nothing for Medicare-covered services, depending on your level of MassHealth Standard (Medicaid) eligibility.

Your yearly limit(s) in this plan:

- \$3,400 for services you receive from in-network providers.

If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.

Refer to the “**Medicare & You**” handbook for Medicare-covered services. For MassHealth Standard (Medicaid)-covered services, refer to the Medicaid Coverage section in this document.

Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.

Is there a limit on how much the plan will pay?

Our plan has a coverage limit every year for certain in-network benefits.
Contact us for the services that apply.

Covered Medical and Hospital Benefits

NOTE:

- Services with a ¹ may require prior authorization
- Services with a ² may require a referral from your doctor

OUTPATIENT CARE AND SERVICES

Acupuncture	<p>There is a limit to how much our plan will pay: You pay nothing.</p> <p>Plan reimburses you up to \$500 per calendar year towards acupuncture visits by a licensed acupuncturist.</p>
Ambulance	You pay nothing
Chiropractic Care ²	<p>Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): You pay nothing</p> <p>See additional MassHealth Standard (Medicaid) covered benefits in the Summary of Medicaid-Covered Benefits section.</p>
Dental Services	<p>Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): You pay nothing</p> <p>See additional MassHealth Standard (Medicaid) covered benefits in the Summary of Medicaid-Covered Benefits section.</p>
Diabetes Supplies and Services ²	<p>Diabetes monitoring supplies: You pay nothing</p> <p>Diabetes self-management training: You pay nothing</p> <p>Therapeutic shoes or inserts: You pay nothing</p> <p>The plan provides coverage for an additional pair of therapeutic, custom-molded shoes for members with diabetes who have severe diabetic foot disease and meet the requirements as defined by Medicare.</p> <p>Referral required for diabetes self-management training only.</p>
Diagnostic Tests, Lab and Radiology Services, and X-Rays <i>(Costs for these services may be different if received in an outpatient surgery setting)</i>	<p>Diagnostic radiology services (such as MRIs, CT scans): You pay nothing</p> <p>Diagnostic tests and procedures: You pay nothing</p> <p>Lab services: You pay nothing</p> <p>Outpatient X-rays: You pay nothing</p> <p>Therapeutic radiology services (such as radiation treatment for cancer): You pay nothing</p>
Doctor's Office Visits ²	<p>Primary care physician visit: You pay nothing</p> <p>Specialist visit: You pay nothing</p> <p>Before you receive services from a specialist, you must obtain a referral from your PCP.</p>

Durable Medical Equipment (wheelchairs, oxygen, etc.) ¹	You pay nothing
Emergency Care	You pay nothing Your plan includes worldwide coverage for emergency care.
Foot Care (podiatry services) ²	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: You pay nothing
Hearing Services ²	Exam to diagnose and treat hearing and balance issues: You pay nothing Routine hearing exam (for up to 1 every year): You pay nothing See additional MassHealth Standard (Medicaid) covered benefits in the Summary of Medicaid-Covered Benefits section.
Home Health Care	You pay nothing
Mental Health Care ²	Inpatient visit: 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 services provided in a general hospital. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 “lifetime reserve days.” These are “extra” days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. You pay nothing Outpatient group therapy visit: You pay nothing Outpatient individual therapy visit: You pay nothing In this plan, you pay nothing for inpatient hospital stays.
Outpatient Rehabilitation ²	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): You pay nothing Occupational therapy visit: You pay nothing Physical therapy and speech and language therapy visit: You pay nothing
Outpatient Substance Abuse ²	Group therapy visit: You pay nothing Individual therapy visit: You pay nothing
Outpatient Surgery ²	Ambulatory surgical center: You pay nothing Outpatient hospital: You pay nothing

OUTPATIENT CARE AND SERVICES NOTE: Services with a ¹ may require prior authorization

<p>Over-the-Counter Items</p>	<p>Please visit our website to see our list of covered over-the-counter items.</p> <p>You pay \$0 for the following OTC items: Methylsulfonylmethane (MSM), Glucosamine/MSM, Chondroitin/MSM, Omega 3/Fish Oil.</p> <p>You have an allowance of \$36 every three months toward Medicare-approved OTC items such as first aid supplies.</p> <p>See additional MassHealth Standard (Medicaid) covered benefits in the Summary of Medicaid-Covered Benefits section.</p>
<p>Prosthetic Devices <i>(braces, artificial limbs, etc.)¹</i></p>	<p>Prosthetic devices: You pay nothing</p> <p>Related medical supplies: You pay nothing</p> <p>The following additional item is covered by the plan: Wigs for members who experience hair loss due to cancer treatment: up to \$350 per calendar year</p>
<p>Renal Dialysis</p>	<p>You pay nothing</p>
<p>Transportation</p>	<p>Not covered</p> <p>See additional MassHealth Standard (Medicaid) covered benefits in the Summary of Medicaid-Covered Benefits section.</p>
<p>Urgently Needed Services</p>	<p>You pay nothing</p> <p>Urgently needed care may be furnished by in-network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. Your plan includes worldwide coverage for urgently needed care.</p>
<p>Vision Services²</p>	<p>Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): You pay nothing</p> <p>Routine eye exam (for up to 1 every year): You pay nothing</p> <p>Contact lenses: You pay nothing</p> <p>Eyeglasses (frames and lenses): You pay nothing</p> <p>Eyeglasses or contact lenses after cataract surgery: You pay nothing</p> <p>Our plan pays up to \$150 every year for contact lenses and eyeglasses (frames and lenses).</p> <p>You must use a participating Vision Care provider (EyeMed Vision Care) to receive the covered Routine Eye Exam benefit. You must purchase your glasses 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.</p>

Services with a ² may require a referral from your doctor

Preventive Care	<p>You pay nothing</p> <p>Our plan covers many preventive services, including:</p> <ul style="list-style-type: none"> • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings: (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • “Welcome to Medicare” preventive visit (one-time) • Yearly “Wellness” visit <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p> <p>Annual physical exam: You pay nothing</p>
Hospice	<p>You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.</p>

INPATIENT CARE

Inpatient Hospital Care	<p>Our plan covers 90 days for an inpatient hospital stay.</p> <p>Our plan also covers 60 “lifetime reserve days.” These are “extra” days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.</p> <p>You pay nothing</p> <p>In this plan, you pay nothing for inpatient hospital stays.</p>
Inpatient Mental Health Care	<p>For inpatient mental health care, see the “Mental Health Care” section of this booklet.</p>
Skilled Nursing Facility (SNF)	<p>Our plan covers up to 100 days in a SNF.</p> <p>You pay nothing</p>

NOTE:

- Services with a ¹ may require prior authorization
- Services with a ² may require a referral from your doctor

PRESCRIPTION DRUG BENEFITS

How much do I pay?

For Part B drugs such as chemotherapy drugs¹: You pay nothing

Other Part B drugs¹: You pay nothing

The Plan will generally cover your drugs at no cost if:

- Your prescription is written by a doctor or other prescriber
- You use a network pharmacy to fill your prescription
- Your drug is on the plan's List of Covered Drugs (Formulary)
- Your drug is used for a medically accepted indication

Initial Coverage

For all drugs: You pay nothing

You may get your drugs at network retail pharmacies and mail order pharmacies.

If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy.

In most cases, your prescriptions are covered only if they are filled at the plan's network pharmacies.

Catastrophic Coverage

You pay nothing

Additional Information About Tufts Health Plan Senior Care Options (HMO SNP)

Your Primary Care Physician (PCP) and what they do for you

When you enroll in our Plan, you must choose a network provider to be your PCP. Your PCP provides your routine care and will also coordinate other covered services you get as a member. If you need certain services, your PCP may refer you to a specialist with whom s/he works on a regular basis to assure your medical care is coordinated effectively. That means, in most cases, you may not have access to the entire Tufts Health Plan network, except for emergency or urgent care situations, out-of-area renal dialysis, or other services. Your PCP's referral may be time limited.

In some cases, your PCP will also need to get prior authorization (prior approval) from us.

Wellness & Weight Management Programs

The plan provides a \$200 annual wellness allowance toward health club membership, nutritional counseling, fitness classes, and wellness programs, including memory fitness activities.

The plan also provides a \$200 annual weight management allowance towards program fees for weight loss programs like WeightWatchers, Jenny Craig, iDiet, or a hospital-based weight loss program.

24/7 Access

If you need to talk to a healthcare professional before you receive care, our Plan's Care Management team is available 24 hours a day, 7 days a week.

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-855-670-5934. Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-855-670-5934. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-855-670-5934。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-855-670-5934。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-855-670-5934. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-855-670-5934. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-855-670-5934 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-855-670-5934. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-855-670-5934번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-855-670-5934. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: اني بدل ةيودال لودج واحةصلاب قلعتت ةلىسأى أن ع ةباجإلل ةيناجملا يروفلا مچرتملا تامدخ مدقن انن! شذحتي ام صخش موقيسي. 1-855-670-5934 لىل انب لاصتالا ىوس لكيلىل سيل، يروف مچرتم لىل ع لوصحلل ةيناجم ةمدخ هذ. كتدعاسمب ةيبرعلا

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-855-670-5934 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-855-670-5934. Un nostro incaricato che parla Italiano vi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-855-670-5934. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-855-670-5934. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-855-670-5934. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-855-670-5934にお電話ください。日本語を話す人 者が支援いたします。これは無料のサービスです。

SUMMARY OF MEDICAID-COVERED BENEFITS

The benefits described below are covered by Medicaid. The benefits described in the Covered Medical and Hospital Benefits section of the Summary of Benefits are covered by Medicare. For each benefit listed below, you can see what MassHealth Standard (Medicaid) covers and what our plan covers. What you pay for covered services may depend on your level of Medicaid eligibility.

NOTE:

- Services with a ¹ may require prior authorization
- Services with a ² may require a referral from your doctor

Benefit	MassHealth Standard (Medicaid)	Tufts Health Plan Senior Care Options
Ambulatory Surgery ²	You pay \$0 for covered services	You pay \$0 for covered services For Medicare-covered services, see the Medicare-covered services section
Adult Day Health	You pay \$0 for covered services	You pay \$0 for covered services
Adult Foster Care (AFC)	You pay \$0 for covered services	You pay \$0 for covered services For Medicare-covered services, see the Medicare-covered services section
Chiropractic Services ²	You pay \$0 for covered services Limited to 20 visits per year	You pay \$0 for covered services Visits 1-20: Referral required Visits 20+: Not covered

COMMUNITY BASED SERVICES—including but not limited to:

Chore Services	You pay \$0 for covered services	You pay \$0 for covered services
Companion Services	You pay \$0 for covered services	You pay \$0 for covered services
Environmental Accessibility Adaptations (Home Modification) ¹	You pay \$0 for covered services	You pay \$0 for covered services
Grocery Shopping and delivery	You pay \$0 for covered services	You pay \$0 for covered services
Home Delivered Meals	You pay \$0 for covered services	You pay \$0 for covered services
Homemaker	You pay \$0 for covered services	You pay \$0 for covered services
Laundry Service	You pay \$0 for covered services	You pay \$0 for covered services
Personal Care Services	You pay \$0 for covered services	You pay \$0 for covered services
Personal Emergency Response System	You pay \$0 for covered services	You pay \$0 for covered services
Respite Care ¹	You pay \$0 for covered services	You pay \$0 for covered services
Social Day Care	You pay \$0 for covered services	You pay \$0 for covered services

Benefit	MassHealth Standard (Medicaid)	Tufts Health Plan Senior Care Options
Transportation (to and from non-medical appointments) ¹	You pay \$0 for covered services	You pay \$0 for covered services
Wander Response System	You pay \$0 for covered services	You pay \$0 for covered services
Day Habilitation Services	You pay \$0 for covered services	You pay \$0 for covered services
Dental Services ¹	You pay \$0 for covered services	<p>You pay \$0 for covered services</p> <p>Prior-authorization required for certain services. Other limits may apply.</p> <p>You must use a DentaQuest provider.</p> <p>Includes but is not limited to:</p> <ul style="list-style-type: none"> • Preventive (cleanings once every 6 months) • Dental X-rays (once every year) • Emergency care, extractions, fillings, dentures, root canal, crowns, implants, and bridges • Oral surgery
Dialysis	You pay \$0 for covered services	You pay \$0 for covered services
Durable Medical Equipment (DME) and Medical/Surgical Supplies ¹	You pay \$0 for covered services	<p>You pay \$0 for covered services</p> <p>For Medicare-covered services, see the Medicare-covered services section</p>
Emergency Services	You pay \$0 for covered services	<p>You pay \$0 for covered services</p> <p>For Medicare-covered services, see the Medicare-covered services section</p>
Geriatric Support Services Coordination (GSSC)	Not covered	You pay \$0 for covered services
Group Adult Foster Care (GAFC)	You pay \$0 for covered services	You pay \$0 for covered services

NOTE: Services with a ¹ may require prior authorization

Benefit	MassHealth Standard (Medicaid)	Tufts Health Plan Senior Care Options
Hearing Services ^{1,2}	You pay \$0 for covered services	You pay \$0 for covered services For Medicare-covered services, see the Medicare-covered services section
Home Health	You pay \$0 for covered services	You pay \$0 for covered services For Medicare-covered services, see the Medicare-covered services section
Hospice	You pay \$0 for covered services	You pay \$0 for covered services For Medicare-covered services, see the Medicare-covered services section

INPATIENT HOSPITAL CARE—all inpatient services, including but not limited to physician, surgery, radiology, nursing, laboratory, other diagnostic and treatment procedures, blood and blood derivatives, semi-private or private room and board, drugs and biologicals, medical supplies, durable medical equipment, and medical surgical/intensive care/coronary care unit, as necessary, in any of the following settings

Acute inpatient hospital	You pay \$0 for covered services	You pay \$0 for covered services
Chronic hospital	You pay \$0 for covered services	You pay \$0 for covered services
Rehabilitation	You pay \$0 for covered services	You pay \$0 for covered services
Psychiatric hospital	You pay \$0 for covered services	You pay \$0 for covered services

Institutional Care	\$0 copay unless MassHealth determines you have a monthly Patient Paid Amount (PPA) for which you are responsible	You pay \$0 for covered services unless MassHealth determines you have a monthly Patient Paid Amount (PPA) for which you are responsible. You must pay the PPA directly to the nursing facility.
Laboratory	You pay \$0 for covered services	You pay \$0 for covered services For Medicare-covered services, see the Medicare-covered services section
Orthotics ¹	You pay \$0 for covered services	You pay \$0 for covered services For Medicare-covered services, see the Medicare-covered services section

Services with a ² may require a referral from your doctor

Benefit	MassHealth Standard (Medicaid)	Tufts Health Plan Senior Care Options
Over-The-Counter (OTC) and prescription Medicines	Certain OTC medications are covered. See approved MassHealth OTC list for additional information: You pay \$0 for covered services	<p>You pay \$0 for covered services</p> <p>Certain OTC medications are covered. Please see your OTC drug list for details.</p> <p>Prescription needed; Non-brand-name (generic) OTC medications will be dispensed unless otherwise approved by plan.</p>
Oxygen and Respiratory Therapy Equipment ¹	You pay \$0 for covered services	<p>You pay \$0 for covered services</p> <p>For Medicare-covered services, see the Medicare-covered services section</p>
Personal Care Attendant (PCA) Services	You pay \$0 for covered services	You pay \$0 for covered services
Physician (Primary)	You pay \$0 for covered services	<p>You pay \$0 for covered services</p> <p>For Medicare-covered services, see the Medicare-covered services section</p>
Physician (Specialty) ²	You pay \$0 for covered services	<p>You pay \$0 for covered services</p> <p>For Medicare-covered services, see the Medicare-covered services section</p>
Podiatry Services ²	You pay \$0 for covered services	<p>You pay \$0 for covered services</p> <p>For Medicare-covered services, see the Medicare-covered services section</p>
Private Duty Nursing	You pay \$0 for covered services	You pay \$0 for covered services
Prosthetic Services and Devices ¹	You pay \$0 for covered services	<p>You pay \$0 for covered service</p> <p>For Medicare-covered services, see the Medicare-covered services section</p>
Radiology and X-ray	You pay \$0 for covered services	<p>You pay \$0 for covered services</p> <p>For Medicare-covered services, see the Medicare-covered services section</p>

NOTE: Services with a ¹ may require prior authorization

Benefit	MassHealth Standard (Medicaid)	Tufts Health Plan Senior Care Options
Therapy (Physical, Occupational, Speech and Hearing) ²	You pay \$0 for covered services	You pay \$0 for covered services For Medicare-covered services, see the Medicare-covered services section
Transportation (to and from medical appointments)	You pay \$0 for covered services	You pay \$0 for covered services For Medicare-covered services, see the Medicare-covered services section
Vision (routine and preventive) ²	\$0 copay for covered services. Covers routine eye exams.	\$0 copay for one routine exam per year. You must see an EyeMed participating network provider. For Medicare-covered services, see the Medicare-covered services section

BEHAVIORAL HEALTH

Inpatient Services—twenty-four-hour services that provide medical intervention for mental health or substance abuse diagnoses		
Inpatient Mental Health Services	You pay \$0 for covered services	You pay \$0 for covered services
Detoxification	You pay \$0 for covered services	You pay \$0 for covered services
Diversionary Services—those Behavioral Health services that are provided as alternatives to inpatient services, including:		
Community Support	You pay \$0 for covered services	You pay \$0 for covered services
Crisis Stabilization	You pay \$0 for covered services	You pay \$0 for covered services
Observation/Holding Beds	You pay \$0 for covered services	You pay \$0 for covered services
Partial Hospitalization	You pay \$0 for covered services	You pay \$0 for covered services
Psychiatric Day Treatment	You pay \$0 for covered services	You pay \$0 for covered services
Residential Substance Abuse Treatment	You pay \$0 for covered services	You pay \$0 for covered services
Structured Outpatient Addiction Programs	You pay \$0 for covered services	You pay \$0 for covered services

Services with a ² may require a referral from your doctor

Benefit	MassHealth Standard (Medicaid)	Tufts Health Plan Senior Care Options
Behavioral Health Emergency Services: Medically necessary services that are available seven days per week, 24 hours per day to provide treatment of any member who is experiencing a mental health or substance abuse problem, or both, including:		
Emergency Screening Services	You pay \$0 for covered services	You pay \$0 for covered services
Medication Management Services	You pay \$0 for covered services	You pay \$0 for covered services
Short Term Crisis Counseling	You pay \$0 for covered services	You pay \$0 for covered services
Short Term Crisis Stabilization Services	You pay \$0 for covered services	You pay \$0 for covered services
Specializing Services	You pay \$0 for covered services	You pay \$0 for covered services
Outpatient Services: Behavioral Health services provided in an ambulatory care setting, such as a mental health or substance abuse clinic, hospital outpatient department, community health center, or Provider's office.		
Mental Health ²	You pay \$0 for covered services	You pay \$0 for covered services
Substance Abuse Services ²	You pay \$0 for covered services	You pay \$0 for covered services
Special Procedures		
Electroconvulsive Therapy	You pay \$0 for covered services	You pay \$0 for covered services
Psychological Neuropsychological Testing ²	You pay \$0 for covered services	You pay \$0 for covered services

QUESTIONS?

Call 1-855-670-5934 // TTY 1-855-670-5936

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: www.thpmp.org/sco

Tufts Health Plan is an HMO-SNP plan with a Medicare contract. Enrollment in Tufts Health Plan depends on contract renewal. Tufts Health Plan Senior Care Options is a voluntary MassHealth (Medicaid) benefit in association with the Executive Office of Health and Human Services (EOHHS) and the Centers for Medicare & Medicaid Services (CMS)

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 co-payments/co-insurance may change on January 1 of each year.

This information may be available in alternate formats. Contact the plan for more information.

This information is available for free in other languages. Please call our Customer Relations number at 1-855-670-5934 or, for TTY users, 1-855-670-5940, Monday - Friday 8:00 a.m. - 8:00 p.m. (from Oct. 1 - Feb. 14 representatives are available 7 days a week, 8:00 a.m. - 8:00 p.m.). After hours and on holidays, please leave a message and a representative will return your call on the next business day.

Esta información está disponible gratuitamente en otros idiomas. Sírvase llamar a nuestro número de Servicio al Cliente al 1-855-670-5940, o, para usuarios con problemas auditivos (TTY), al 1-800-208-9562, de lunes a viernes, desde las 8:00 a.m. hasta las 8:00 p.m. (desde el 1 de octubre hasta el 14 de febrero hay representantes disponibles los 7 días de la semana, desde las 8:00 a.m. hasta las 8:00 p.m.). Después del horario de atención y en días feriados, por favor deje un mensaje y un representante le devolverá su llamada el día laborable siguiente.



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