TUFTS MEDICARE PREFERRED HMO PLANS | 2018

MEMBER GUIDE

How to Get the Most Out of Your Plan

5

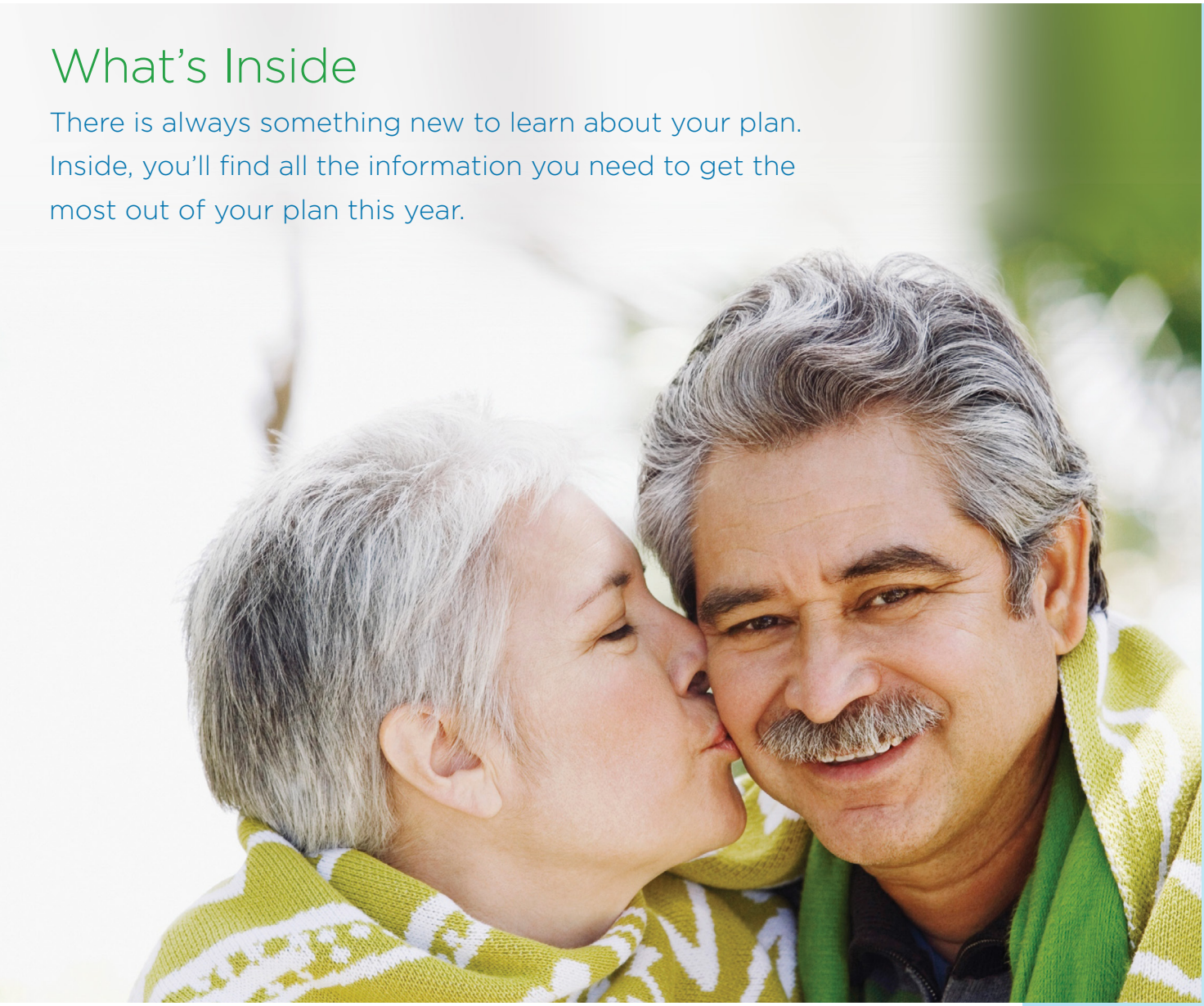
Medicare's highest rating for quality

TUFTS Health Plan

H2256_2018_333 Accepted

What's Inside

There is always something new to learn about your plan. Inside, you'll find all the information you need to get the most out of your plan this year.



Call us with any questions

1-800-701-9000 // (TTY: 1-800-208-9562)

Monday–Friday, 8 a.m.–8 p.m. (From October 1 to 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 the next business day.

Visit our website

Search for a doctor, get plan documents and forms, information on how to use your plan, healthy living tips, and much more!

www.thpmp.org

5 stars means you can change your plan!

For the third consecutive year, Tufts Medicare Preferred HMO plans received 5 out of 5 stars from Medicare! This is Medicare's highest rating for quality.

One of the biggest advantages of being a member of a 5-star plan is that you can switch your plan once during the year if you need to. This means you are not locked into your plan for the year.

If you need to increase your coverage, want a plan without a prescription drug deductible or just want a lower monthly premium, you can switch to another one of our HMO plans up until November 30th. We have a range of HMO plans and can help you find the one that fits you best.

Members who receive their benefits from a current or former employer may not be able to switch their plan.

1 | The Basics of How Your Plan Works

There is a network

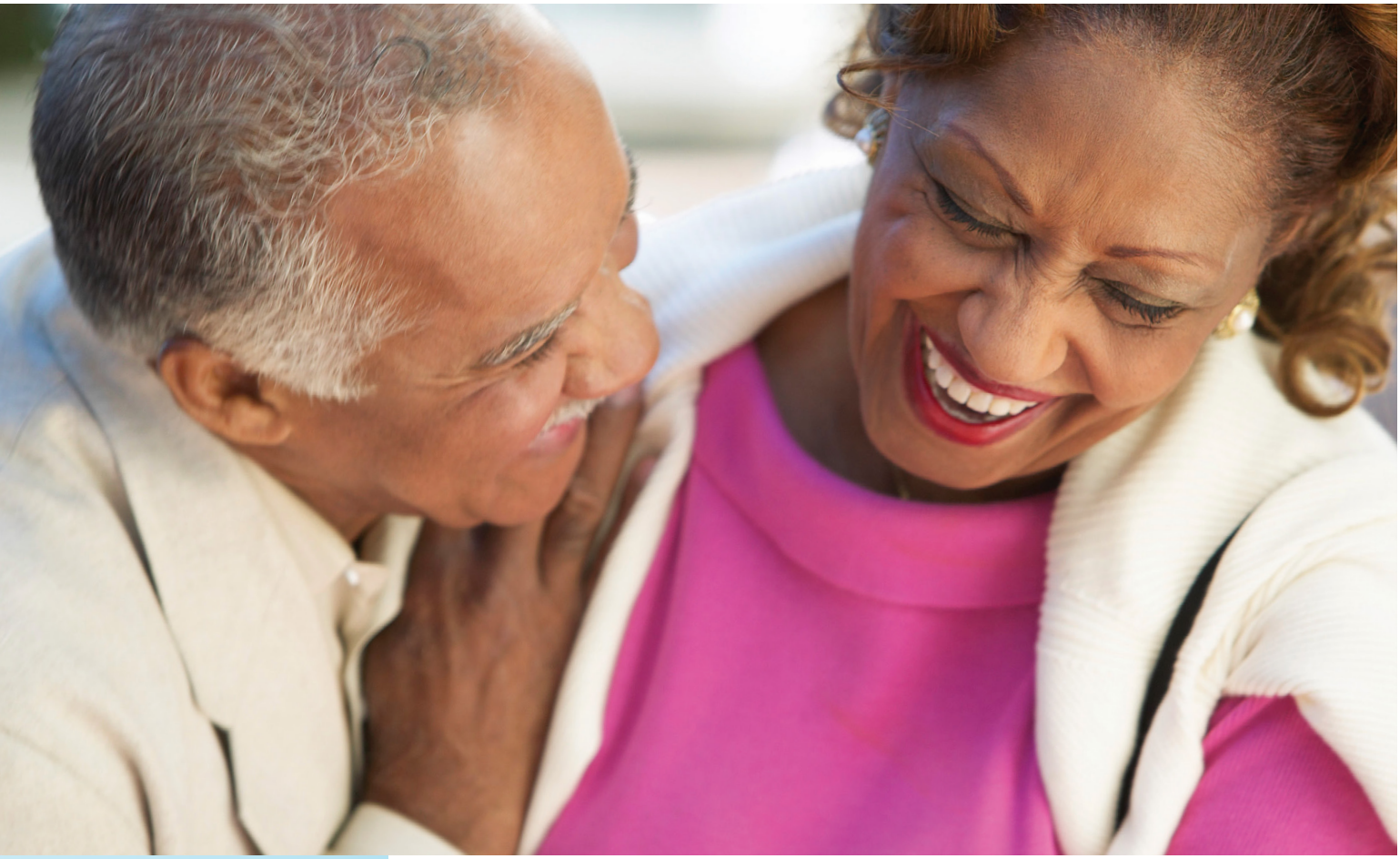
Your plan is a Health Maintenance Organization (HMO) plan. In an HMO plan there is a network made up of doctors, specialists, hospitals and pharmacies. Your plan offers coverage for services you get within the network. It's important to remember, in most cases, if you get care from a doctor or facility out of our network, you will not be covered. (This does not apply to emergency or urgent care. You are covered for emergency and urgent care anywhere in the world.)

You share the cost of your benefits

Some of your benefits have a $0 copay, but in most cases, when you use a medical service (such as seeing your doctor or a hospital stay) or fill a prescription, you pay a copay or coinsurance. A copay is a set amount that covers a portion of the service or drug cost. For example, you might pay $10 or $20 for a doctor visit or prescription drug. Coinsurance is a percentage of the cost you pay when you receive certain services. Copays, coinsurance and deductibles are examples of cost-sharing. For a list of cost-sharing amounts, see the easy-to-use chart on page 12.

Your doctor oversees your care

In an HMO plan, you choose a doctor to be your primary care physician (PCP). Your PCP provides routine checkups, preventive care and treatment for common illnesses. Your PCP is responsible for coordinating all the care you receive. This includes referring you to a specialist for services your doctor can't provide. Only your PCP can refer you to a specialist. This way your PCP knows all the care you are getting and can make informed decisions about your health. By coordinating your care, your PCP can also help you avoid unnecessary expenses such as duplicate tests and identify safety concerns, such as harmful drug interactions.



You need a referral to see a specialist

In an HMO plan, you need to have a referral from your PCP in order for the specialist visit to be covered. If a specialist refers you to another specialist, you would need to check with your PCP first. **Only your PCP can refer you to a specialist.** By issuing all your referrals, your PCP is able to make sure you get the care that is right for you.

Your doctor has a referral circle

A referral circle is the team of specialists your PCP works with. Not all Tufts Health Plan Medicare Preferred physicians are included in your PCP's referral circle. This means you are only able to see a specialist within your PCP's referral circle. Your PCP must give you a referral before you can see a specialist. The Provider Directory lists PCPs by medical group. The medical group section in the Provider Directory tells you which specialists and facilities are in your PCP's referral circle. The Provider Directory is available on our website or you can request a copy by calling Customer Relations.

2 | Getting Care

During regular office hours

Your primary care physician (PCP) oversees your care and is responsible for providing your routine or basic care. Call your PCP to:

- Get a checkup
- Make an appointment
- Get a referral to a specialist
- Ask general questions about your health

After regular office hours

For non-emergency situations when your PCP's office is closed, call your PCP and a physician on call will help you.

In an emergency

If you believe your health is in serious danger, call 911 or go to the nearest emergency room or hospital. You do not need to get approval or a referral from your PCP if you have a medical emergency.

In an urgent situation

An urgent situation is when you need medical care right away but your health is not in serious danger. Call your PCP in an urgent care situation. If you are unable to see your PCP, you are covered for urgent care provided by another doctor in our network or a doctor outside our network. You do not need a referral from your PCP for urgent care but, whenever possible, you should see your PCP for urgent care.

When traveling

You are covered anywhere in the world for emergency or urgent care. You can be outside our service area for up to six consecutive months and still be covered for emergency or urgent care. You do not need a referral from your PCP before getting emergency or urgent care. Routine care, such as a physical, is not covered outside our service area, so remember to schedule routine care before or after your travel plans. If you receive emergency or urgent care when traveling, you may need to pay out of pocket. Simply save your receipts, and call Customer Relations for reimbursement details.[1] (Our service area is the state of Massachusetts except for Berkshire, Franklin, Dukes and Nantucket Counties.)

[1]*Reimbursement applies to emergency and urgent care situations only. You may be responsible for any copays that apply.*

Our Customer Relations team is located right here in Massachusetts

When you call us, you talk to representatives who understand your plan and are part of your community. You can expect to have your questions answered quickly with knowledge, honesty and respect. If you have any questions about your coverage, choosing a doctor, a bill you received, or anything else about your plan, we can help. We are committed to helping you get the most out of your plan.

1-800-701-9000 // (TTY: 1-800-208-9562)

Monday–Friday, 8 a.m.–8 p.m. (From October 1 to 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 the next business day.

What makes our customer service different?

For a behind-the-scenes look at our Customer Relations team, watch these two short videos! Just go to: **www.thpmp.org/crdifference**.

How to change your doctor

You can change your PCP for any reason, at any time. To change your PCP call Customer Relations or, if you signed up for a secure online account, you can make the change through your account on our website. PCP changes will begin the first of the month following your change request.

What happens if your PCP retires?

If your PCP retires or leaves the plan, we send a letter to let you know. The letter includes a PCP change form and a return envelope so you can select a new PCP. This letter is generally sent at least 30 days before your PCP leaves the plan. You can also call Customer Relations to select a new PCP.

How to find a new PCP

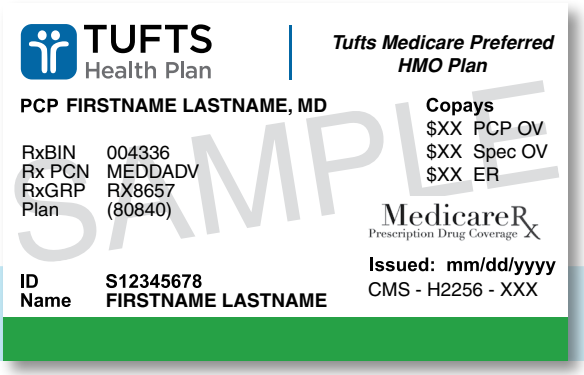
To find a new PCP, check the Provider Directory for a PCP in your area. Our Provider Directory lists all the providers in our network. The online version of the Provider Directory on our website has the most up-to-date information. Before selecting a new PCP, check to make sure he or she is accepting new patients by calling Customer Relations or checking the online Provider Directory on our website.

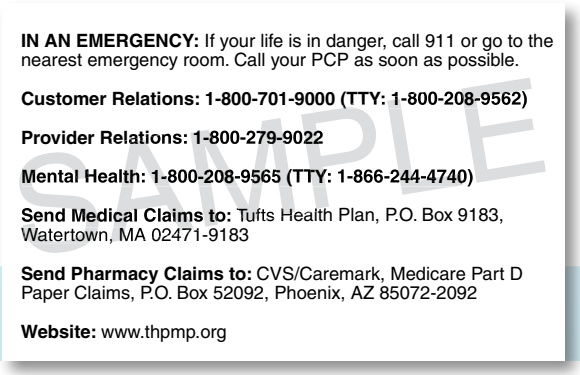
You can request a Provider Directory

The most up-to-date list of doctors, specialists, hospitals and pharmacies in our network is available on our website. Visit thpmp.org to access our online, searchable directory. But if you would like a printed Provider Directory, you can request to have one mailed to you (please note, it is over 900 pages). Just call Customer Relations to request a copy.

How to get a new ID card

Your member ID card is needed each time you see your doctor or fill a prescription. If you lose your card and need a replacement, you can request one by calling Customer Relations. You will receive your new card in the mail in 7–10 business days.





How to make paying your premium easier

Pay your premium online

Sign up for a secure online account, and pay your premium online. Details are on page 8. Sign up at **www.thpmp.org/registration**.

Pay your premium automatically

You can have your monthly premium automatically deducted from your checking or savings account each month by signing up for Electronic Funds Transfer (EFT). There is no charge to use EFT. To sign up, fill out the EFT form available on our website and mail it with a voided check.

Have your premium taken out of your monthly Social Security check

If you didn't sign up for SSA deduction but would like to, just call Customer Relations and we will be happy to set this up for you.

Please note, premium payment features may not apply if you receive your benefits from a current or former employer.

Your plan is now at your fingertips

Download the new Tufts Health Plan mobile app to access plan information easily from your mobile device!

- Check recent claims
- See costs and plan limits for benefits
- View, email or fax your member ID card
- Search for a doctor or facility in the Provider Directory
- Plus, more features coming soon!

To download the app, visit your device's app store, and search for "Tufts Health Plan" in the search bar.

How to check claims and referrals online

Access your personal account information on our website by creating a secure online account! It's easy to create an account that lets you:

- Pay your monthly premium
- View your claims history
- View your current and past referrals
- View your monthly Explanation of Benefits (EOB) documents

How to get your documents online with eDelivery

Signing up for eDelivery is a great way to have all your important documents in one place and easily view or print them whenever you want. All you need to do is create an account on our website. You'll get your documents faster, reduce clutter, and always know where to find them. The online versions are the same as the printed versions and you can always request a paper copy if you need one. Plus, when you create an account, you can pay your monthly premium, view your claims history, view your referrals, and more!

With eDelivery, you can get the following documents electronically:

- Annual Notice of Changes (annual letter listing any changes to your coverage)
- Evidence of Coverage (your benefit and cost information)
- Formulary (list of covered drugs)
- Provider Directory (list of doctors and pharmacies)
- Medical Explanation of Benefits (list of your medical services)

Signing up only takes a few minutes. If you have any questions, just call Customer Relations. To sign up go to: **www.thpmp.org/registration**.

How to switch your plan

Did you know you can switch to another Tufts Medicare Preferred HMO plan once during the year? Because our plans have a 5-star rating from Medicare, you can switch to another one of our HMO plans once during the year until November 30, 2018. Maybe you're looking for a plan with a lower monthly premium, or lower copays when you go to the doctor. If so, we have a range of HMO plans that may better fit your needs. You can compare our plans by using the chart on page 12. To switch your plan or to learn more, call Customer Relations.

Please note: may not apply if you receive your benefits from a current or former employer.

How to give permission to someone to discuss your benefits

Did you know if your spouse or family member calls us we can't answer questions about your coverage? HIPAA (Health Insurance Portability and Accountability Act) is a federal law that prevents your health plan from sharing information about your coverage with anyone, including your spouse or family members. But you can give someone the ability to contact us on your behalf! Just call Customer Relations. It's important to select someone you trust who can discuss your benefits in case of an emergency.

You can also fill out an Appointment of Personal Representative Form. This form gives someone permission to call on your behalf and make decisions related to your coverage. Once we have this form on file, the person you identify can call us and discuss your benefit information and make decisions about your plan. The authorization is good for one year unless you specify an earlier expiration date.

How to work with a Care Manager

A Care Manager can help you if you get sick, have an injury, or are looking for ways to stay healthy. Care Managers are nurses who work closely with your doctor and help guide you through the health care system to ensure you receive the services and resources that are right for you. From helping you understand your medications to planning a recovery process before a surgery, your Care Manager is there to support you. They can also help you get to your doctor's office, help prevent return trips to the hospital, and answer any questions or concerns you might have. For more information about working with a Care Manager, call Customer Relations.

Use videos to learn about your plan

We put together a series of short videos to answer some of the questions we hear most often from members, such as:

- How does the referral process work?
- Will the donut hole affect you?
- How does a prescription drug deductible work?
- How to change your doctor
- How to find out if your drug is covered
- What's the difference between an annual physical and a wellness visit?

You can find them all on our website at: **www.thpmp.org/video-library**.

How to get extra discounts and savings

As a Tufts Health Plan Medicare Preferred member you get extra discounts on a variety of programs and services. With Preferred Extras you can save on programs that help you lead a healthy lifestyle! For all the details including a complete list of discounts, see the Preferred Extras section on our website at **www.thpmp.org/preferred-extras**.

- **Hearing aid discount**

  Save on a wide selection of hearing aids from major manufacturers.

- **Save with CVS Caremark® Extra Care Health Card**

  Save 20% on certain CVS/pharmacy brand, non-prescription health-related items.

- **Nutrition and weight loss discounts**

  Save on Jenny Craig®, DASH for Health® and more!

- **Health and wellness discounts**

  Save on brain exercise programs, stress reduction programs, massage therapy, acupuncture and more!

- **Save on programs to help you at home**

  Great discounts on home delivered meals, personal emergency response systems, and home modification services.

- **Plus many more!**

Please note, restrictions may apply to the discounts listed above. For complete details, see the the Preferred Extras section on our website at thpmp.org/preferred-extras.

Discounts and services included in the Preferred Extras program are not plan benefits and are not subject to the Medicare appeals process.

Great benefits that help you save

Get $300 or more to join programs that help you stay healthy[2]

Our wellness reimbursements help you lead a healthy lifestyle. And they pay you back:

- Depending on the plan you are in, you can get up to $150 or $250 each year for fees you pay for membership in a qualified health or fitness club; wellness programs; acupuncture; fitness classes such as yoga, Pilates, Tai Chi, and aerobics; and much more![3] For details, go to **www.thpmp.org/wellness-allowance**.
- Plus, use our weight management programs reimbursement allowance to reach your weight loss goals! You can get up to $150 toward the program fees of Weight Watchers®, Jenny Craig®, or hospital-based weight loss programs![4] For details, see your Evidence of Coverage (EOC) booklet.

Get $150 back for eyeglasses

You can get up to $150 toward the full retail price (not sale price) for one complete pair of prescription eyeglasses or contact lenses from a provider in the EyeMed Vision Care Network. Or, get up to $90 toward the price for one complete pair of eyeglasses or contact lenses from a store not in the EyeMed network. (Discounts cannot be combined.) EyeMed Vision Care is the network we use to provide your eyewear benefit. The EyeMed network includes more than 26,000 eye care providers including national chains such as LensCrafters, Sears Optical, Target Optical and JCPenney Optical. For details, go to **www.thpmp.org/eyewear-benefit**.

You pay $0 for health screenings

Getting regular screenings is one of the best ways to stay healthy. Screenings help find illness or disease before you feel sick. You pay a $0 copay for many screenings such as a physical exam, breast cancer screening, cholesterol screening, glaucoma screening, prostate cancer screening, and many more.

You're covered when traveling

It's comforting to know you are covered for emergency and urgent care anywhere in the world. See page 4 for details.

[2]Members in our Saver Rx plan can get up to $400 a year. For details see your Evidence of Coverage booklet or call Customer Relations. [3]$150 (or $250 for members of our Saver Rx plan) is the total reimbursement amount each year (January 1–December 31) whether used for a health club, fitness classes, nutritional counseling or wellness programs. [4]$150 is the total reimbursement amount each year (January 1–December 31). This benefit does not cover costs for pre-packaged meals/foods, books, videos, scales, or other items or supplies.

4 | Plan Costs

Medical Coverage | Our Rx plans include Prescription Drug Coverage (see page 16).

This is a quick reference guide to your covered services. For more complete benefit information, see your Evidence of Coverage (EOC) booklet.

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	$0	Not offered	$46.00	$103.00	$132.00	$133.00	$166.00	$200.00
Essex, Suffolk	$0	$38.00	$66.00	$123.00	$152.00	$156.00	$189.00	$221.00
Hampden, Hampshire	Not offered	Not offered	$24.00	$41.00	$70.00	$67.00	$100.00	$132.00
Middlesex, Norfolk, Plymouth	$0	Not offered	$46.00	$103.00	$132.00	$133.00	$166.00	$200.00
Worcester	$0	$40.00	$68.00	$112.00	$147.00	$152.00	$186.00	Not offered
Plan Medical Costs								
Medical deductibles				No medical deductible				
Annual out-of-pocket maximum[3]	$4,500	$3,400		$3,400		$3,400		$3,400
Copays								
DOCTOR OFFICE VISITS								
Primary care	$20/visit	$10/visit		$10/visit		$10/visit		$10/visit
Specialist	$45/visit	$40/visit		$25/visit		$15/visit		$15/visit
EMERGENCY SERVICES								
Emergency room	$80/visit	$100/visit		$100/visit		$100/visit		$100/visit
Ambulance services	$300/day	$275/day		$225/day		$125/day		$90/day
Urgently needed care	$20–$45/visit	$10–$40/visit		$10–$25/visit		$10–$15/visit		$10–$15/visit

[1]You must continue to pay your Medicare Part B premium.
[2]Not available in all counties.
[3]Comprises all your medical copays/coinsurance—your out-of-pocket costs will never exceed this amount.
Please note: costs may differ if you receive your benefits from a current or former employer. Some services may require prior authorization. See your Evidence of Coverage (EOC) booklet.

Copays	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]
PREVENTIVE CARE								
The preventive services listed here all have a $0 copay for all HMO plans:	• **Abdominal aortic aneurism screenings** • **Alcohol misuse screening** • **Annual physical exam** • **Annual wellness visit** • **Bone mass measurement** • **Cancer screening** (colorectal, prostate, breast, cervical/vaginal, lung) • **Cardiovascular disease risk reduction visit** • **Depression screening** • **Diabetes screening** • **HIV screening** • **Immunizations** • **In-home safety assessment** • **Medicare Diabetes Prevention Program (MDPP)** (new as of 4/1/18) • **Obesity screening** • **Sexually Transmitted Infection (STI) screening** • **Smoking and tobacco use cessation counseling** • **"Welcome to Medicare" preventive visit**							
INPATIENT CARE								
Hospice	$0 (paid for by Original Medicare)							
Inpatient hospital coverage (general acute)	$350/day, days 1–5. $0/day after day 5.	$275/day, days 1–5. $0/day after day 5.		$200/day, days 1–5. $0/day after day 5.		$300/stay; you will not pay more than $900/year.		$200/stay; you will not pay more than $400/year.
Inpatient hospital coverage (rehabilitation or long-term acute care)	$350/day, days 1–5. $0/day after day 5.	$275/day, days 1–5. $0/day after day 5.		$200/day, days 1–5. $0/day after day 5.		$300/stay; you will not pay more than $900/year.		$200/stay; you will not pay more than $400/year.
Inpatient mental health care	$315/day, days 1–5. $0/day after day 5.	$275/day, days 1–5. $0/day after day 5.		$200/day, days 1–5. $0/day after day 5.		$300/stay; you will not pay more than $900/year.		$200/stay; you will not pay more than $400/year.
Skilled nursing facility care (SNF)	$0/day, days 1–20. $160/day, days 21–44. $0/day, days 45–100.	$20/day, days 1–20. $140/day, days 21–44. $0/day, days 45–100.		$20/day, days 1–20. $100/day, days 21–44. $0/day, days 45–100.		$20/day, days 1–20. $60/day, days 21–44. $0/day, days 45–100.		$20/day, days 1–20. $0/day, days 21–100.

Please note: costs may differ if you receive your benefits from a current or former employer. Some services may require prior authorization. See your Evidence of Coverage (EOC) booklet.

Copays (contd.)								
	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]
OUTPATIENT AND LAB SERVICES								
Blood services	$0	$0		$0		$0		$0
Cardiac/pulmonary rehabilitation	$0	$0		$0		$0		$0
Physical, occupational or speech/language therapy[4]	$40/visit	$30/visit		$20/visit		$15/visit		$15/visit
Diagnostic and laboratory tests, X-rays	$10 copay (separate from office visit copay)			$5 copay (separate from office visit copay)		$0		$0
Diagnostic radiology services	$300/day	$250/day		$100/day		20% up to $75/day		20% up to $75/day
Radiation therapy	$60	$60		$0		$0		$0
Mental health care	$40/visit	$40/visit		$25/visit		$15/visit		$15/visit
Substance abuse services	$40/visit	$40/visit		$25/visit		$15/visit		$15/visit
Surgery (outpatient)	$350/day	$250/day		$150/day		$100/day		$75/day
Surgical supplies, such as dressings	$0	$0		$0		$0		$0
Splints, casts, and other devices used to reduce fractures and dislocations	$0	$0		$0		$0		$0
VISION AND HEARING								
Annual routine vision exam	$45	$40		$25		$15		$15
Annual eyewear benefit	$150 per year towards eyewear at an Eyemed participating provider or $90 per year at non-participating providers							
Annual diabetic retinopathy screening	$45	$40		$25		$15		$15
Annual glaucoma screening (for people at high risk for glaucoma)	$0	$0		$0		$0		$0
Medicare-covered eye exams	$45	$40		$25		$15		$15
Annual routine hearing exam	$45	$40		$25		$15		$15
Diagnostic hearing exam	$45	$40		$25		$15		$15
Hearing aid allowance	Not covered			Covered up to $500 every 3 years				

[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. Some services may require prior authorization. See your Evidence of Coverage (EOC) booklet.

Copays (contd.)	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]
ADDITIONAL BENEFITS								
Wellness allowance[5]	$250/yr	$150/yr		$150/yr		$150/yr		$150/yr
Acupuncture[6]	$250/yr	$150/yr		$150/yr		$150/yr		$150/yr
Bathroom safety equipment	20%	20%		10%		10%		10%
	Raised toilet seat: 1 every 5 years; bathroom grab bars: 2 every 5 years; tub seat: 1 every 5 years							
Weight management programs	$150/yr	$150/yr		$150/yr		$150/yr		$150/yr
Chiropractic services	$15/visit	$15/visit		$15/visit		$15/visit		$15/visit
Dental services	See your Evidence of Coverage (EOC) booklet for covered services and copay amounts							
Podiatry services	$45/visit	$40/visit		$25/visit		$15/visit		$15/visit
Diabetes self-management training, services and supplies	$0	$0		$0		$0		$0
Durable medical equipment (DME) and related supplies	20%	20%		10%		10%		10%
Home health agency care, including home infusion therapy	$0	$0 ($30/visit for physical therapy services provided in the home)		$0 ($20/visit for physical therapy services provided in the home)		$0		$0
Prosthetic devices and related supplies	20%	20%		10%		10%		10%
SilverSneakers™ Fitness	Not covered	$0 (available to members who live in Worcester County only)						Not covered
Wigs	$500/yr	$500/yr		$500/yr		$500/yr		$500/yr
Kidney disease services	$0	$0		$0		$0		$0
Medical nutrition therapy	$0	$0		$0		$0		$0
Medicare Part B prescription drugs (including chemotherapy)	20%	0%		0%		0%		0%
Partial hospitalization services	$0	$0		$0		$0		$0

[5]$150 (or $250 for members in our Saver Rx plan) is the total reimbursement amount each year (January 1–December 31) whether used for a health club, fitness class, wellness programs, or nutritional counseling. Reimbursement requests are due March 31 of the following year.

[6]Acupuncture services are eligible for reimbursement under the annual Wellness Allowance benefit. This amount is not in addition to your annual Wellness Allowance benefit.

Please note: costs may differ if you receive your benefits from a current or former employer. Some services may require prior authorization. See your Evidence of Coverage (EOC) booklet.

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: Non-preferred generic	$12	$24	$8	$16
Tier 3: Preferred brand	$47	$94	$47	$94
Tier 4: Non-preferred brand	$100	$300	$100	$300
Tier 5: Specialty tier	25%	N/A	26%	N/A

	HMO Value Rx		HMO Prime Rx	
DEDUCTIBLE	$0 for Tiers 1–2; $300 for Tiers 3–5		No deductible	
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: Non-preferred generic	$8	$16	$8	$16
Tier 3: Preferred brand	$47	$94	$47	$94
Tier 4: Non-preferred brand	$100	$300	$100	$300
Tier 5: Specialty tier	27%	N/A	33%	N/A

	HMO Prime Rx Plus[2]	
DEDUCTIBLE	No deductible	
COPAYS	Retail 30-day supply	Mail Order 90-day supply
Tier 1: Preferred generic	$2	$4
Tier 2: Non-preferred generic	$4	$8
Tier 3: Preferred brand	$30	$60
Tier 4: Non-preferred brand	$80	$240
Tier 5: Specialty tier	33%	N/A

[2]Not available in all counties.

Please note: costs may differ if you receive your benefits from a current or former employer. Some services may require prior authorization. See your Evidence of Coverage (EOC) booklet.

Plan Drug (Rx) Costs cont.								
	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]
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 • 35% of costs for Part D brand drugs plus a portion of the dispensing fee[7]							• Tier 1 copays for generic drugs on Tier 1 • Tier 2 copays for generic drugs on Tier 2 • 44% for all other generic drugs • 35% of costs for Part D brand drugs plus a portion of the dispensing fee[7]
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 **or,** • $3.35 per prescription for Part D generic drugs • $8.35 per prescription for Part D brand drugs							

[7]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. Some services may require prior authorization. See your Evidence of Coverage (EOC) booklet.

Where to find complete benefit information

- **Evidence of Coverage (EOC)**

  Find complete benefit, out-of-pocket costs and plan information.

- **Formulary**

  The list of all the drugs we cover. You can find the formulary on our website, or give us a call and we will send you a printed copy.

- **Online at www.thpmp.org:**

  Doctor search—The most up-to-date list of doctors in our network.

  Drug search—Search the list of drugs we cover.

  Video library—Short videos that explain how to use your plan.

  Article library—Extensive list of articles that explain how your plan works.

5 | Using Your Prescription Drug Plan

Look up your drugs

It's a good idea to look up your prescription drugs to make sure your drug is covered, find out what tier your drug is on, and see if your drug has any special requirements. The formulary (drug list) lists all the drugs we cover alphabetically and by medical condition so they're easy to find. You can find the formulary on our website, or give us a call and we will send you a printed copy.

What if your drug isn't listed?

If your drug is not listed on the formulary, you may be able to get a temporary supply in certain circumstances. This gives you time to talk to your doctor and see if another prescription would meet your needs. Temporary supplies for new members are generally a 30-day supply, and available one time only during the first 90 days of your membership.

What is a tier?

Every drug in the formulary (drug list) has a tier number. You'll find the tier number listed next to each drug. The tier number determines the general cost of the drug. In general, the lower the tier, the lower your cost for the drug. Plus, if the retail amount for a drug is lower than your copays, you pay the lower amount.

Generic drugs can help you save money

A generic drug has the same active-ingredient formula as a brand name drug and can help save you money on prescription drug costs. Generic drugs are rated by the Food and Drug Administration (FDA) to be as safe and effective as brand name drugs. If you take a brand name drug, ask your doctor if there is a generic version that is right for you.

Please note, prescription drug information may be different if you receive your benefits from a current or former employer.

Does your drug have a special requirement?

Some drugs have special requirements. The formulary (drug list) will tell you if a drug has special requirements, such as:

- **Prior Authorization (PA)**—Some drugs require you or your doctor to request special permission from us before you fill your prescription.
- **Step Therapy (ST)**—Some drugs require you to try a less expensive drug first. Medications with step therapy have at least one comparable medication that you must try first.
- **Quantity Limit (QL)**—For quality and safety reasons, certain drugs have a limit on the amount you can get at one time. For example, a medication may have a limit of 30 pills in 30 days.

If your drug has a special requirement, you or your doctor may need to take extra steps in order for your drug to be covered. Call Customer Relations or check your Evidence of Coverage (EOC) for details on what you can do to get coverage for the drug. You can also ask us to remove a special requirement by requesting an "exception." Your EOC includes information on how to request an exception. We are not able to remove special requirements in all cases, but each exception request is reviewed to see if removing the restriction is possible.

How to save money with mail order

Mail order service delivers medications that you refill each month right to your home. Depending on the plan you are in and the tier your drug is on, you may be able to save up to $47 by using mail order for a 90-day supply of prescription medications. That's a potential savings of up to $188 a year!

To sign up for mail order, just fill out the Caremark Mail Order form available on our website or call FastStart at CVS Caremark toll-free at 1-866-788-5144.

For more complete information, see your Evidence of Coverage (EOC) booklet.

Please note, prescription drug information may be different if you receive your benefits from a current or former employer.

For an easy-to-understand overview of how our drug plan works, go to **www.thpmp.org/members/prescription-drug-coverage**.

What is the donut hole?

The "donut hole" is a term used to describe a gap in prescription drug coverage. It happens when drug costs reach a certain amount during the year.[5] All Medicare Part D plans have a donut hole. Most members don't reach the donut hole, but it's good to understand how it works. If the total cost of your prescription drugs reach $3,750 during 2018 you will enter the donut hole (also known as the coverage gap stage). In the donut hole, you may have to pay a higher price for your medications until January 1st of the upcoming year unless you move into Catastrophic Coverage. For more details see page 17. If you want to know how close you are to reaching the donut hole, check your Caremark Explanation of Benefits (EOB) that is mailed to prescription drug plan members each month or call Customer Relations.

[5]*Applies to members who have prescription drug coverage with their plan. May not apply if you receive your benefits from a current or former employer.*

QUESTIONS?

Call 1-800-701-9000 // TTY: 1-800-208-9562

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

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, and/or copayments/co-insurance may change on January 1 of each year.

The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Medicare evaluates plans based on a 5-star rating system. Star ratings are calculated each year and may change from one year to the next. For more information on plan ratings, go to www.medicare.gov.

Tufts Medicare Preferred HMO plans received 5 out of 5 stars for contract years 2016, 2017 and 2018.

TUFTS Health Plan