	Tufts Health Plan Medicare Preferred HMO 1-866-974-0118								Tufts Health Plan 1-877-218-4835
	Tufts Medicare Preferred Saver Rx HMO	Tufts Medicare Preferred Basic No Rx HMO	Tufts Medicare Preferred Basic Rx HMO	Tufts Medicare Preferred Value No Rx HMO	Tufts Medicare Preferred Value Rx HMO	Tufts Medicare Preferred Prime No Rx HMO	Tufts Medicare Preferred Prime Rx HMO	Tufts Medicare Preferred Prime Rx+ HMO	Senior Care Options (Dual Eligible) SNP
Plan Number	H2256-028	H2256-042	H2256-026	H2256-019	H2256-018	H2256-016	H2256-015	H2256-001	H2256-029
Barnstable	$0.00		$46.00	$103.00	$132.00	$133.00	$166.00	$200.00	$0
Bristol	$0.00		$46.00	$103.00	$132.00	$133.00	$166.00	$200.00	$0
Essex	$0.00	$38.00	$66.00	$123.00	$152.00	$156.00	$189.00	$221.00	$0
Hampden			$24.00	$41.00	$70.00	$67.00	$100.00	$132.00	$0
Hampshire			$24.00	$41.00	$70.00	$67.00	$100.00	$132.00	$0
Middlesex	$0.00		$46.00	$103.00	$132.00	$133.00	$166.00	$200.00	$0
Norfolk	$0.00		$46.00	$103.00	$132.00	$133.00	$166.00	$200.00	$0
Plymouth	$0.00		$46.00	$103.00	$132.00	$133.00	$166.00	$200.00	$0
Suffolk	$0.00	$38.00	$66.00	$123.00	$152.00	$156.00	$189.00	$221.00	$0
CO-PAYS - Beneficiary Costs	In Network	In Network	In Network	In Network	In Network	In Network	In Network	In Network	In Network
Health Plan Deductible	None	None	None	None	None	None	None	None	None
PCP	$20	$10	$10	$10	$10	$10	$10	$10	$0
Specialist	$45	$40	$40	$25	$25	$15	$15	$15	$0
Inpatient Hospital	days 1-5: $350/day	days 1–5: $275/day	days 1–5: $275/day	days 1–5: $200/day	days 1–5: $200/day	$300 copay per vist up to $900 per year	$300 copay per vist up to $900 per year	$200 copay per vist up to $400 per year	$0
Outpatient Services/Surgery	Ambulatory: $350 Hospital: $350	Ambulatory: $250 Hospital: $250	Ambulatory: $250 Hospital: $250	Ambulatory: $150 Hospital: $150	Ambulatory: $150 Hospital: $150	Ambulatory: $100 Hospital: $100	Ambulatory: $100 Hospital: $100	Ambulatory: $75 Hospital: $75	$0
Outpatient Rehab	$40/visit	$30/visit	$30/visit	$20/visit	$20/visit	$15/visit	$15/visit	$15/visit	$0
Diagnostic Tests and Labs	$10: Labs,Tests, & X-Rays $60: Therapeutic Radiology $300/day: Diagnostic Radiology	$10: Labs,Tests, & X-Rays $60: Therapeutic Radiology $250/day: Diagnostic Radiology	$10: Labs,Tests, & X-Rays $60: Therapeutic Radiology $250/day: Diagnostic Radiology	$5: Labs,Tests, & X-Rays $0: Therapeutic Radiology $100/day: Diagnostic Radiology	$5: Labs,Tests, & X-Rays $0: Therapeutic Radiology $100/day: Diagnostic Radiology	$0: Labs,Tests, Therapeutic Radiology & X-Rays 20% up to $75/day: Diagnostic Radiology	$0: Labs,Tests, Therapeutic Radiology & X-Rays 20% up to $75/day: Diagnostic Radiology	$0: Labs,Tests, Therapeutic Radiology & X-Rays 20% up to $75/day: Diagnostic Radiology	$0
Skilled Nursing	days 1–20 $0/day days 21–44 $160/day days 45–100 $0	days 1–20 $20/day days 21–44 $140/day days 45–100 $0	days 1–20 $20/day days 21–44 $140/day days 45–100 $0	days 1–20 $20/day days 21–44 $100/day days 45–100 $0	days 1–20 $20/day days 21–44 $100/day days 45–100 $0	days 1–20 $20/day days 21–44 $60/day days 45–100 $0	days 1–20 $20/day days 21–44 $60/day days 45–100 $0	days 1–20 $20/day days 21–100 $0	$0
Emergency Room	$80	$100	$100	$100	$100	$100	$100	$100	$0
Ambulance	$300	$275	$275	$225	$225	$125	$125	$90	$0
DME	20%	20%	20%	10%	10%	10%	10%	10%	$0
Diabetic Supplies	$0	$0	$0	$0	$0	$0	$0	$0	$0

Part B Medications	20%	$0	$0	$0	$0	$0	$0	$0	$0
Annual Maximum	$4,500	$3,400	$3,400	$3,400	$3,400	$3,400	$3,400	$3,400	
Drug Deductible	$400 (Tier 3, Tier 4, Tier 5)	N/A	$350 (Tier 3, Tier 4, Tier 5)	N/A	$300 (Tier 3, Tier 4, Tier 5)	N/A	None	None	None
Drug Co-pays Tier 1	$6		$4		$4		$4	$2	$0
Tier 2	$12		$8		$8		$8	$4	$0
Tier 3	$47		$47		$47		$47	$30	$0
Tier 4	$100		$100		$100		$100	$80	$0
Tier 5	25%		26%		27%		33%	33%	$0
Gap Generic Coverage	No		No		No		No	Yes, T1 and T2	Yes
Vision (Yes/No)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Hearing (Yes/no)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Dental (Yes/No)	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Yes