

ADVANTAGE HMO SAVER

SUMMARY OF BENEFITS

With Tufts Health Plan Advantage HMO Saver, health care services may be covered subject to the plan's deductible, covered with a copayment, or covered in full.

The deductible is the amount you must first pay out of pocket before many services are covered. The deductible is calculated each calendar year. Once you meet the deductible, the plan covers in full services that are subject to the deductible for the remainder of the calendar year.

In addition, Advantage HMO Saver is fully compatible with health savings accounts (HSAs), which are designed specifically to help with individuals' future health care expenses.

As an Advantage HMO Saver member:

- You must choose a primary care provider (PCP) from the Tufts Health Plan network of providers.
- In most cases, your network PCP must provide or authorize (provide a referral for) your care.
- You do not need a referral for emergency care.

How services are covered with Advantage HMO Saver


In general, the Advantage HMO Saver plan covers preventive and medically necessary health care services and supplies when they are provided or authorized by your network PCP. Services may be:

Covered subject to the plan's deductible: Certain covered services—usually those used to diagnose, treat, or monitor health conditions (for example, an MRI)—are subject to the plan's deductible. Note: Services subject to the plan's deductible may also be

performed during or in conjunction with preventive services (for example, during an office visit). The individual and family deductibles for this plan are listed below. **Note: There is no individual deductible on a family plan. If you have two or more family members enrolled in the plan, and only one member receives services that are subject to the deductible in a calendar year, that member alone must meet the full family deductible before services subject to the deductible are covered. The same calculation applies to the out-of-pocket maximum.**

- **Covered in full or with a copayment:** In most cases with this plan, preventive health care services are covered in full or with a copayment, and are not subject to the deductible. Generally, preventive health care services are the services your provider provides to help you stay healthy. Preventive health services are needed at all ages. They might be office visits for preventive care for children and adults; tests (also call screenings) to evaluate your general health or the health of certain parts of your body; measurements; immunizations (or shots) for children and adults; certain advice about health; or special tests at certain times in your life. (Please visit www.tuftshealthplan.com/members to review the most recent Massachusetts Health Quality Partners preventive care recommendations for every age.)

Please note that this is a summary of benefits only. For more detailed benefit information, please refer to this plan's member benefit document.

 This health plan meets Minimum Creditable Coverage standards and will satisfy the individual mandate that you have health insurance.

Prescription Drug Coverage	For up to a 30-day supply at a participating retail pharmacy	For up to a 90-day supply through our mail order service
Tier 1	\$10 after deductible	\$20 after deductible
Tier 2	\$30 after deductible	\$60 after deductible
Tier 3	\$45 after deductible	\$90 after deductible
Deductible and Out-of-Pocket Maximum (per calendar year)	Individual plans	Family plans
Deductible	\$2,500	\$5,000
Out-of-Pocket Maximum (includes deductible and copays)	\$4,375	\$8,750
Outpatient Medical Care (No PCP referral is necessary for OB/GYN visits, spinal manipulation, routine eye exams, or mammograms)		
Routine Physical Exams (including most preventive screenings. Please note: some services performed during a routine office visit may be subject to your deductible.)		\$25 per visit
Non-routine office visits (including PCP and specialist consultations)		Covered in full after deductible
Well-Child Care		\$25 per visit
Routine Outpatient Maternity Care (This office visit copayment will apply per visit up to 10 visits per pregnancy. After 10 visits, these services are covered in full for the remainder of your pregnancy.)		\$25 per visit
Non-routine Outpatient Maternity Care		Covered in full after deductible
Routine Eye Exams (1 visit every 24 months)		\$25 per visit
Nutritional Counseling (When medically necessary)		Covered in full after deductible
Preventive Immunizations		Covered in full
Preventive Pap Smears and Mammograms		Covered in full
Non-preventive Immunizations		Covered in full after deductible
Non-preventive Pap Smears and Mammograms		Covered in full after deductible
Allergy Injections		Covered in full after deductible
Colonoscopy		Covered in full
Diagnostic Procedures		Covered in full after deductible
Diagnostic Imaging - General Imaging (such as X-rays and ultrasounds)		Covered in full after deductible

Diagnostic Imaging - High-Tech Imaging (MRIs, CT/CAT Scans, PET Scans, and Nuclear Cardiology)	Covered in full after deductible
Diagnostic Lab Tests	Covered in full after deductible
Speech and Short-term Physical/Occupational Therapy	Covered in full after deductible
Spinal Manipulation (12 visits per calendar year)	Covered in full after deductible
Day Surgery	Covered in full after deductible
Inpatient Hospital Care (Semi-private room, unless private room is medically necessary)	
All Hospital Services (Acute Care) and Maternity Care	Covered in full after deductible
Skilled Nursing in Skilled Nursing Facility (up to 100 days per calendar year)	Covered in full after deductible
Emergency Care	
In Provider's Office	Covered in full after deductible
In Emergency Room	Covered in full after deductible
Mental Health*	
Outpatient Care (up to 24 visits per calendar year)	Covered in full after deductible
Inpatient Care (Services provided at a designated facility for up to 60 days per calendar year)	Covered in full after deductible
Substance Abuse**	
Outpatient Care (Alcohol and drug treatment, detoxification)	Covered in full after deductible
Inpatient Care (Services provided at a designated facility)	Covered in full after deductible
Other Health Services	
Durable Medical Equipment (\$1,500 calendar year maximum)	Covered in full after deductible
Ambulance Service	Covered in full after deductible
Hospice Care	Covered in full after deductible
Home Health Care	Covered in full after deductible

Great Savings While You Get Healthy

In addition to your covered benefits, we offer great savings on a wide variety of health products, services, and treatments—from fitness club memberships to acupuncture and massage therapy to wellness programs. You can save while you're taking care of your health. To learn more, visit tuftshealthplan.com and click on Discounts on the Members tab.

*Outpatient and inpatient mental health services are treated the same as any other medical condition when provided as required by law for the following: biologically-based mental disorders (schizophrenia; schizoaffective disorder; major depressive disorder; bipolar disorder; paranoia and other psychotic disorders; obsessive-compulsive disorder; panic disorder; delirium and dementia; affective disorders; eating disorders; substance abuse disorders; autism; post-traumatic stress disorder; and any other mental disorders added by the Commissioners of the Department of Mental Health and the Division of Insurance); certain mental, behavioral or emotional disorders for children under age 19; and rape-related mental or emotional disorders. See your Tufts Health Plan member benefit document for more information.

**Due to changes in Massachusetts law, effective for renewals on and after July 1, 2009, there is no longer a visit or day limit for treatment of substance abuse disorders.

There are some services that the plan does not cover. These include, but are not limited to: A service or supply not described as a covered service in your Tufts Health Plan member benefit document • Exams required by a third party, such as your employer, an insurance company, school, or court • Cosmetic surgery or any other cosmetic procedure, except certain reconstructive procedures described in your Tufts Health Plan member benefit document • Experimental or investigational drugs, services, and procedures • Eyeglasses or contact lenses, except as described in your Tufts Health Plan member benefit document • Blood, blood donor fees, blood storage fees, blood substitutes, blood banking, cord blood banking, or blood products, except as described in your Tufts Health Plan member benefit document • Drugs for use outside of a hospital, except as covered under Prescription Drug Coverage • Personal comfort items • Custodial care • A service furnished to someone other than the member • Routine foot care, except as described in your Tufts Health Plan member benefit document • Charges incurred for stays in a covered facility beyond the discharge hour • Care for conditions that state or local law requires to be treated in a public facility • Medical or surgical procedures for sexual reassignment and reversal of voluntary sterilization • Foot orthotics, except therapeutic/molded shoes for an individual with severe diabetic foot disease • Assisted reproductive technology (e.g. IVF) procedures for non-Massachusetts residents • Spinal manipulation services for members age 12 and under • Except for Emergency care, a service, supply or medication that is obtained outside of the 50 United States • Private duty nursing (block or non-intermittent nursing) • Hearing aids.

This is a summary only. Please refer to the member benefit document for a detailed explanation of your coverage. If there is a difference between the information in this benefit summary and your member benefit document, the terms of your member benefit document will govern. If you have additional questions, please call a member services specialist at 1-800-462-0224.

Offered by Tufts Associated Health Maintenance Organization, Inc.

Massachusetts Requirement to Purchase Health Insurance: As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector Web site (www.mahealthconnector.org).

This health plan meets Minimum Creditable Coverage standards that are effective January 1, 2009 as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you will satisfy the statutory requirement that you have health insurance meeting these standards. This disclosure is for minimum creditable coverage standards that are effective January 1, 2009. Because these standards may change, review your health plan material each year to determine whether your plan meets the latest standards. If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its Web site at www.mass.gov/doi.