ADVANTAGE HMO SAVER SUMMARY OF BENEFITS

TUFTS Health Plan
No one does more to keep you healthy.

With Tufts Health Plan's Advantage HMO Saver plan, you enjoy quality coverage for your health care needs. Health care services may be covered subject to the plan's deductible, coinsurance, covered with a copay, or covered in full. The deductible is the amount you need out of your own pocket before the health plan begins to pay for covered medical and pharmacy services.

In addition, Advantage HMO Saver is compatible with health savings accounts (HSAs), which are designed specifically to help with your future health care costs. For a list of financial institutions that manage HSAs, please see your employer or our website.

As an Advantage HMO Saver member:

- You must choose a primary care provider (PCP) from the Tufts Health Plan network.
- In most cases, your network PCP must give or refer your care.

How services are covered with Advantage HMO Saver

The Advantage HMO Saver plan covers preventive and medically needed health care services and supplies when they are given or referred by your network PCP. Services may be:

- **Covered subject to the plan's deductible:** All covered pharmacy services and certain covered medical services—usually those used to diagnose, treat, or monitor health conditions (for example, an MRI)—are subject to the plan's deductible. Services subject to the plan's deductible may also be performed at the same time you are having a preventive office visit with your provider. Please see the chart below for information about your specific deductible. **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 subject to the deductible in a calendar year, that member must meet the full family deductible before services are covered. The same calculation applies to the out-of-pocket maximum, or yearly limit.**
- **Covered with a copay:** You pay a certain copay at the time you receive covered services.
- **Covered in full:** This plan covers preventive services in full—they are not subject to the deductible or a copay. Preventive services, for the most part, are the services your provider offers to help you stay healthy. These are needed at all ages. They might be office visits for routine checkups for children and adults, tests (also called screenings) to measure your overall 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. Also, once you have met your plan's out-of-pocket maximum, Tufts Health Plan pays for covered services for the rest of your plan's year.
- **Covered subject to coinsurance:** You pay coinsurance for durable medical equipment. Coinsurance is the percentage of cost you must pay for some covered services.

Out-of-pocket Maximum: Your deductible, coinsurance, and copays go toward your out-of-pocket maximum, or yearly limit. Once you reach your limit, Tufts Health Plan begins payment for covered medical and pharmacy services.

Please note that this is a summary of benefits only. For complete benefit information, please refer to your member benefit document, available in your secure account at tuftshealthplan.com.

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	$15 after deductible	$30 after deductible
Tier 2	$30 after deductible	$60 after deductible
Tier 3	$50 after deductible	$150 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, coinsurance and copays)	$4,375	$8,750
Preventive Services		
Routine Physical Exams (including preventive immunizations, preventive Pap smears and mammograms, well-child care visits, annual gynecological exams, and most preventive screenings. Please note: some services performed during a routine office visit may be subject to your deductible.)		Covered in full
Screening for Colon or Colorectal Cancer in the Absence of Symptoms		Covered in full
Outpatient Medical Care (No PCP referral is necessary for OB/GYN visits, spinal manipulation, routine eye exams, or mammograms)		
Non-routine Office Visits (including PCP and specialist consultations, and urgent care)		Covered in full after deductible
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
Routine eye exams with an EyeMed Vision Care provider (1 visit every 24 months)		$25 per visit
Nutritional Counseling (when medically necessary)		Covered in full after deductible
Allergy Injections		Covered in full after deductible

Service	Coverage
Speech Therapy (when medically necessary)	Covered in full after deductible
Short-term Physical and Occupational Therapy (30 visits for each type of service per calendar year)	Covered in full after deductible
Spinal Manipulation (12 visits per calendar year)	Covered in full after deductible
Non-preventive Pap Smears and Mammograms	Covered in full after deductible
Colonoscopies Generally Associated With Symptoms (Including Family History of Cancer)	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
Day Surgery	Covered in full after deductible
Inpatient Hospital Care (semiprivate 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 Emergency Room	Covered in full after deductible
Mental Health and Substance Abuse	
Outpatient Care (up to 24 visits per calendar year except as described below)	Covered in full after deductible
Inpatient Care (Services provided at a designated facility for up to 60 days per calendar year except as described below)	Covered in full after deductible
Other Health Services	
Durable Medical Equipment	70% after deductible
Ambulance Service	Covered in full after deductible
Hospice Care	Covered in full after deductible
Home Health Care	Covered in full after deductible

*Outpatient and inpatient mental health services are treated the same as any other medical condition and are not subject to a benefit limit when provided as required by law for the following: biologically-based mental disorders, as defined by Massachusetts law (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. All other mental health services are subject to the benefit limit described above. See your Tufts Health Plan member benefit document for more information.

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, a 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 described in your Tufts Health Plan member benefit document • 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 be treated in a public facility • Medical or surgical procedures for sexual reassignment and reversal of voluntary sterilization • Foot orthotics, except therapeutic or molded shoes for an individual with severe diabetic foot disease • Spinal manipulation services for members age 12 and under • Private-duty nursing (block or nonintermittent nursing) • Hearing aids • Except for Emergency care and urgent care while traveling, a service, supply or medication that is obtained outside of the 50 United States.

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 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.