

HEALTHPACT

SUMMARY OF BENEFITS

With Tufts Health Plan's Healthpact, you and your family are covered by a unique health insurance plan. Healthpact provides you with comprehensive coverage including preventive care, office visits, prescriptions and more. Healthpact has two levels of benefits: Basic and Advantage. Both levels cover the same services, but the Advantage level has much lower out-of-pocket expenses for you.

To qualify for Advantage-level benefits, members must commit to specific ongoing enrollment requirements, and adopt the 5 Healthpact Principles:

1. Select a Primary Care Provider (PCP) no later than 21 days prior to enrollment date
2. Complete a Health Risk Appraisal Form no later than 21 days prior to enrollment date (not required for adolescent members)

3. Pledge to maintain or achieve a healthy weight
4. Pledge to stay smoke-free or participate in smoking cessation programs
5. Participate in disease management programs as appropriate

Members who do not meet ongoing eligibility requirements will automatically be enrolled in the Basic level benefit plan.

With Healthpact, members work with their PCP to get healthy and stay healthy, and are rewarded with lower out-of-pocket costs.

	ADVANTAGE			BASIC					
PRESCRIPTION DRUG COVERAGE									
Pharmacy Deductible	N/A			Prescriptions are covered with copays after a \$250 Individual/\$500 Family plan year deductible					
For up to a 30-day supply at a participating retail pharmacy	Tier 1 - \$10	Tier 2 - \$40	Tier 3 - \$75	Tier 1 - \$10	Tier 2 - \$40	Tier 3 - \$75			
For up to a 90-day supply through our mail order service	Tier 1 - \$20	Tier 2 - \$80	Tier 3 - \$150	Tier 1 - \$20	Tier 2 - \$80	Tier 3 - \$150			
LIFETIME MAXIMUM AND DEDUCTIBLE	INDIVIDUAL		FAMILY		INDIVIDUAL		FAMILY		
Lifetime Maximum	N/A		N/A		\$1,000,000		N/A		
Deductible (per plan year)	\$750		\$1500		\$5,000		\$10,000		
OUTPATIENT MEDICAL CARE (No PCP referral is necessary for OB/GYN visits, or mammograms)	PCP		SPECIALIST		PCP		SPECIALIST		
Most Provider Office Visits	\$10 per visit		\$50 per visit		\$30 per visit		\$60 per visit		
Routine Physical Exams (including most preventive screenings. Please note: some services performed during a routine office visit may be subject to your deductible.)	Covered in full		Covered in full		Covered in full		Covered in full		
Well-Child Care	\$10 per visit		\$50 per visit		\$30 per visit		\$60 per visit		
OB/GYN Visits	\$10 per visit		\$10 per visit		\$30 per visit		\$30 per visit		
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.)	\$10 per visit		\$10 per visit		\$30 per visit		\$30 per visit		
Nutritional Counseling (When medically necessary)	\$10 per visit		\$50 per visit		\$60 per visit		\$60 per visit		
Preventive Immunizations	Covered in full		Covered in full		Covered in full		Covered in full		
Preventive Pap Smears and Mammograms	Covered in full		Covered in full		Covered in full		Covered in full		
Non-preventive Immunizations	Covered in full after deductible			Covered in full after deductible					
Non-preventive Pap Smears and Mammograms	Covered in full after deductible			Covered in full after deductible					
Allergy Injections	Covered in full after deductible			Covered in full after deductible					
Colonoscopy	Covered in full after deductible			Covered in full after deductible					

	ADVANTAGE		BASIC	
OUTPATIENT MEDICAL CARE (No PCP referral is necessary for OB/GYN visits, spinal manipulation, routine eye exams, or mammograms)	PCP	SPECIALIST	PCP	SPECIALIST
Diagnostic Procedures	Covered in full after deductible		Covered in full after deductible	
Diagnostic Imaging - General Imaging (such as X-rays and ultrasounds)	Covered in full after deductible		Covered in full after deductible	
Diagnostic Imaging - High-Tech Imaging (MRIs, CT/CAT Scans, PET Scans, and Nuclear Cardiology)	\$100 per visit remainder subject to deductible		\$250 per visit remainder subject to deductible	
Diagnostic Lab Tests	Covered in full after deductible		Covered in full after deductible	
Speech and Short-term Physical/Occupational Therapy	Covered in full after deductible		Covered in full after deductible	
Day Surgery	Covered in full after deductible		\$500 per admission remainder subject to 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		\$750 per admission remainder subject to deductible	
Skilled Nursing in Skilled Nursing Facility (up to 100 days per plan year)	Covered in full after deductible		\$750 per admission remainder subject to deductible	
EMERGENCY CARE	PCP	SPECIALIST	PCP	SPECIALIST
In Doctor's Office	\$10 per visit	\$50 per visit	\$30 per visit	\$60 per visit
In Emergency Room	\$200 per visit		\$200 per visit	
MENTAL HEALTH				
Outpatient Care (up to 30 visits per plan year)	\$50 per visit		\$60 per visit	
Inpatient Care	Covered in full after deductible		\$750 per admission remainder subject to deductible	
SUBSTANCE ABUSE				
Outpatient Care (Alcohol and drug treatment, detoxification) (Up to 30 visits per plan year for treatment)	\$50 per visit		\$60 per visit	
Inpatient Care	Covered in full after deductible		\$750 per admission remainder subject to deductible	
OTHER HEALTH SERVICES				
Durable Medical Equipment (\$750 plan year maximum)	Covered in full		Covered in full	
Ambulance Service	Covered in full		Covered in full	
Hospice Care	Covered in full after deductible		Covered in full after deductible	
Home Health Care	Covered in full after deductible		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 save while you're taking care of your health. To learn more, visit tuftshealthplan.com and click on Discounts on the Members tab.

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 • Spinal manipulation services • 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) • Routine eye exams.

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 1-800-682-8059.

Offered by Tufts Associated Health Maintenance Organization, Inc.

Note for Massachusetts Residents: The Basic level of this health plan does not meet Minimum Creditable Coverage standards and will not satisfy the Massachusetts requirement that you have health insurance. If you have this coverage, you may be subject to a Massachusetts state tax penalty.