

# 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 or coinsurance, 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 plan year. Once you meet the deductible, the plan covers in full services that are subject to the deductible for the remainder of the plan 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. For a list of financial institutions that administer 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 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 plan 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:** You pay the applicable copayment at the time you receive covered health care services. With this plan, preventive services are covered in full and are not subject to the deductible. Generally, preventive services are the services your provider provides to help you stay healthy. Preventive services are needed at all ages. They might be office visits for routine physicals 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.
- **Covered subject to coinsurance:** You pay the deductible, then coinsurance for durable medical equipment. Coinsurance is a percentage of the covered medical costs you are responsible for paying.

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

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 plan year)	Individual plans	Family plans
Deductible	\$1,500	\$3,000
Out-of-Pocket Maximum (includes deductible, coinsurance and copays)	\$2,625	\$5,250
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.)		\$20 per visit
Non-routine office visits (including PCP and specialist consultations)		Covered in full after deductible
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.)		\$20 per visit
Non-routine Outpatient Maternity Care		Covered in full after deductible
Preventive Immunizations		Covered in full
Non-preventive Immunizations		Covered in full after deductible
Preventive Pap Smears and Mammograms		Covered in full
Non-preventive Pap Smears and Mammograms		Covered in full after deductible
Colonoscopy (without surgical intervention)		Covered in full
Colonoscopy (with surgical intervention)		Covered in full
Well-Child Care		\$20 per visit
Routine eye exams with an EyeMed Vision Care provider (1 visit every 24 months)		\$20 per visit
Nutritional Counseling (When medically necessary)		Covered in full after deductible
Allergy Injections		Covered in full after deductible

Speech and Short-term Physical/Occupational Therapy (30 visits for each service type per plan year)	Covered in full after deductible
Spinal Manipulation (12 visits per plan year)	Covered in full after deductible
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
<b>Inpatient Hospital Care (Semi-private room, unless private room is medically necessary)</b>	
All Hospital Services (Acute Care) and Maternity Care	Covered in full after deductible
Skilled Nursing in Skilled Nursing Facility (up to 100 days per plan year)	Covered in full after deductible
<b>Emergency Care</b>	
In Doctor's Office	Covered in full after deductible
In Emergency Room	Covered in full after deductible
<b>Mental Health</b>	
Outpatient Care (up to 30 visits per plan year)	Covered in full after deductible
Inpatient Care	Covered in full after deductible
<b>Substance Abuse</b>	
Outpatient Care (Alcohol and drug treatment, detoxification) (Up to 30 hours per plan year for treatment)	Covered in full after deductible
Inpatient Care	Covered in full after deductible
<b>Other Health Services</b>	
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

**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 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 to be treated in a public facility • Medical or surgical procedures for sexual reassignment and reversal of voluntary sterilization • Spinal manipulation services for members age 12 and under • Except for Emergency care or Urgent care while traveling, a service, supply or medication that is obtained outside of the 50 United States • Private duty nursing (block or non-intermittent nursing).

**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 1-800-682-8059.**

Offered by Tufts Associated Health Maintenance Organization, Inc.